STATE'S EXHIBIT NO. 90-A

(EVIDENCE ENVELOPE)

NOT ADMITTED

STATE'S EXHIBIT NO. 91

(NOTE: PHYSICAL EVIDENCE, BULLET, IN THE CUSTODY OF THE HARRIS COUNTY SHERIFF'S OFFICE.)

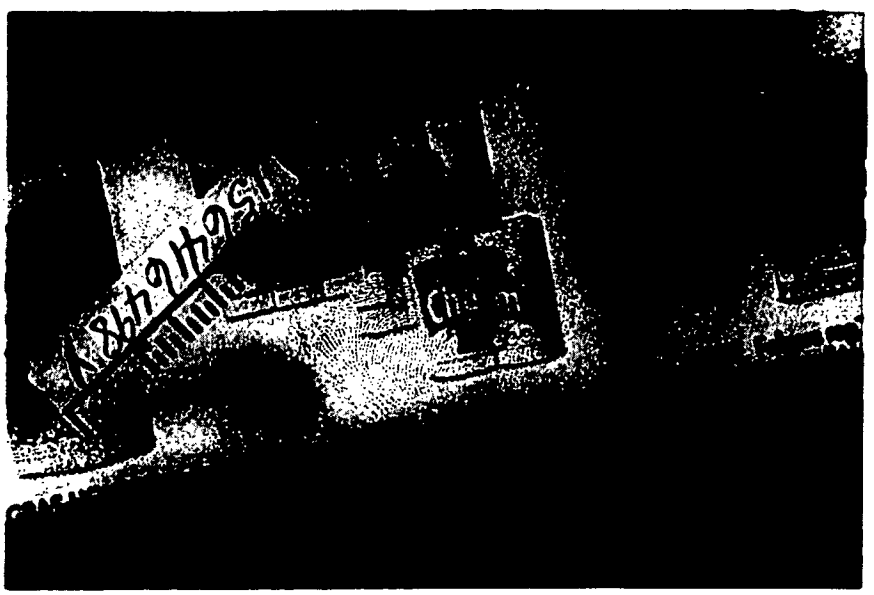
STATE'S EXHIBIT NO. 92

STATE'S
EXHIBIT
92

STATE'S EXHIBIT NO. 93

(NOTE: PHYSICAL EVIDENCE, BAG/CLIPPINGS, IN THE CUSTODY OF THE DISTRICT CLERK'S OFFICE.)

STATE'S EXHIBIT NO. 94



Newspaper Clippings

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STATE'S EXHIBIT NO. 95

(PRINT CARD)

NOT ADMITTED

STATE'S EXHIBIT NO. 96

(NOTE: PHYSICAL EVIDENCE, FIREARMS CHART, IN THE CUSTODY OF THE DISTRICT CLERK'S OFFICE.)

STATE'S EXHIBIT NO. 97

(LIVE BULLET FROM LEXUS)

NOT ADMITTED

STATE'S EXHIBIT NO. 98

(BULLET)

NOT ADMITTED

STATE'S EXHIBIT NO. 99

Joye M. Carter, M.D., FCAP
Chief Medical Examiner

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OFFICE OF THE MEDICAL EXAMINER OF HARRIS COUNTY
JOSEPH A. JACHIMCZYK FORENSIC CENTER
1885 OLD SPANISH TRAIL
HOUSTON, TEXAS 77054-2098

AUTOPSY REPORT

Case 98 - 3366

December 8, 1998

ON THE BODY OF

Terrance Lawayn Gibson
16702 Skyblue Ln.
Houston, Texas

CAUSE OF DEATH: Gunshot wound of left chest.

MANNER OF DEATH: Homicide.

Roger P. Milton Jr. MD 1-14-99
Roger P. Milton Jr., M.D. Date
Assistant Medical Examiner

Reviewed and signed by:

Joye M. Carter MD 22 Jan 99
Joye M. Carter, M.D., FCAP Date
Chief Medical Examiner

PENGAD Bayonne, N.J.
STATE'S EXHIBIT
99

POSTMORTEM EXAMINATION ON THE BODY OF

Terrance Lawayn Gibson
16702 Skyblue Ln.
Houston, Texas

HISTORY: This 22 year old black male was transported to Hermann Hospital, Houston, Texas, arriving at 12:14 a.m. on December 7, 1998. He was pronounced dead at 12:24 a.m. on December 7, 1998.

AUTOPSY: The autopsy was performed in the Joseph A. Jachimczyk Forensic Center of Harris County by Assistant Medical Examiner Roger P. Milton, Jr., M.D., pursuant to Article 49.25, Texas Code of Criminal Procedure, beginning at 8:00 a.m., on December 8, 1998.

CLOTHING: The body was received unclad in a plastic white body bag.

EVIDENCE OF MEDICAL INTERVENTION: A white plastic neck collar was in place. An endotracheal tube was in the mouth. Electrocardiogram electrodes were on the anterior chest and abdomen. Intravascular catheters were in the anterior left chest and the right antecubital fossa.

EXTERNAL APPEARANCE: The body was that of a well developed, well nourished, black male who measured 69 inches and weighed 183 pounds, appearing compatible with the stated age of 22 years. Rigor mortis was developed in the extremities and the jaw. Purple fixing livor mortis was on the posterior surfaces of the body, except in areas exposed to pressure. The head was symmetrical and covered by short black, curly hair which measured 1/4 inch over the crown with close-cut hair on the sides and back of the head. Facial hair consisted of a beard and moustache. The irides were brown and the pupils were bilaterally dilated to 4 millimeters. The sclerae and conjunctivae were clear. There was minimal conjunctival drying within the palpebral fissures. The corneae were mildly cloudy. The nose was central and atraumatic. Natural teeth were in good condition. The upper right central incisor was rimmed with gold colored metal. The left upper central incisor was chipped. Both ears were pierced once. The neck was symmetrical and atraumatic. A gunshot entrance wound was on the upper lateral left chest. There were a few well-healed scars of the upper anterior chest measuring up to 3/8 by 3/16 inch. There were no palpable chest masses. The anterior left chest had a 5-1/2 by 5-1/2 inch tattoo of a hand holding a gun. The abdomen was mildly protuberant and covered with sparse body hair. There were no palpable abdominal masses and a few well-healed scars measured up to 1/8 by 1/8 inch. The pubic hair was moderately abundant. The external genitalia were those of a normal adult male. The penis

was not circumcised. The scrotum showed purple drying. The anterior right leg had a 3 by 4 inch cluster of healing and fresh abrasions, measuring up to 3 by 3/4 inch. The posterior medial right leg and popliteal fossa had a 7 by 3-1/2 inch cluster of linear, superficial abrasions. The lower extremities showed multiple, well-healed scars, including a 2 by 1-1/4 inch scar of the medial right leg, a 3 by 1 inch scar of the lateral left thigh, and 2-1/2 by 3/4 inch scar of the lateral left leg. A 1/8 by 3/16 inch abrasion was on the lateral aspect of the left leg. The lateral aspect of the right arm had a tattoo of a skull with the word "Heartless" beneath it, measuring 4-1/2 by 2-1/2 inches and a tattoo reading "Only God Can Judge Me", measuring 3 by 4 inches. There were multiple, well-healed scars of the right upper extremities including a 2 by 1/8 inch scar of the anterior right arm. There was a 3/4 by 1/4 inch abrasion of the medial right elbow. The lateral aspect of the right arm had a 1/8 by 1/8 inch scab. The dorsal aspect of the distal right 3rd digit had a 1/8 by 1/32 inch abrasion. The lateral aspect of the left arm had a 4-1/2 by 4 inch tattoo of a panther and the word "Fearless". There were a few well-healed scars of the left upper extremity. The dorsal left forearm had a 1/4 by 1/4 inch healing abrasion. There were a few well-healed scars of the dorsal aspects of the hands and forearms. The appropriate number of digits were on the feet and hands. The back showed multiple, well-healed scars. The anus, perineum and back were otherwise unremarkable.

INTERNAL EXAMINATION: Section: The chest and abdomen were opened by the usual Y-shaped incision. The abdominal fat layer at the level of the umbilicus measured 1 inch in maximum thickness. The chest plate was removed. The left pleural cavity contained 1700 milliliters of liquid and clotted blood. The peritoneal cavity contained 400 milliliters of clotted and liquid blood. There were extensive fibrous adhesions of the right pleural cavity. The peritoneal cavity and the left pleural cavity were smooth and glistening. The internal organs were in their usual locations and had normal anatomic relationships to one another.

HEART: The heart weighed 325 grams and had mild to moderate amounts of epicardial adipose tissue. The epicardium was gray-brown, smooth, and glistening. The coronary arteries arose in the usual locations and were normally located over the surface of the heart. There was no atherosclerosis. The myocardium was red-brown and had no nodules or fibrosis. The right and left ventricles were of normal size and configuration. The cardiac valve cusps and leaflets were normal in number and configuration. There was mild atherosclerosis of the aortic root. The interventricular septum was intact. The thoracoabdominal aorta had a bullet wound laceration measuring 3/4 by 3/4 inch in width.

LUNGS: The right and left lungs weighed 650 grams and 350 grams, respectively. The left lung was collapsed. The inferior aspects of the upper and lower lobes of the left lung showed contusions. The inferior lateral aspect of the lower lobe of the left lung had a 3/4 inch laceration with surrounding contusion. The bronchi were opened to the bronchioles and contained blood-tinged fluid. The mucosa was red-tan and moderately congested. The pleural surfaces were otherwise purple to pink and intact. There were patchy fibrous pleural adhesions of the right lung. There was no anthracotic pigment deposition. The parenchyma of the right lung was mildly firm. There was minimal congestion of the left lung and moderate congestion of the right lung. There was no tumor, infection, or cavitation noted.

LIVER: The liver weighed 1200 grams. A 1-1/2 inch lacerated wound track was on the posterior, superior lateral right lobe. The capsule was otherwise red-tan, smooth, glistening and intact. The parenchyma was otherwise mildly to moderately firm, red-brown, and unremarkable. The gallbladder contained 2 milliliters of green-yellow bile. There were no gallstones. The hepatobiliary ducts were patent.

Pancreas: The pancreas weighed 125 grams. The external and cut surfaces were gray-tan. There were no nodules or other gross lesions.

Adrenals: The adrenal glands were surrounded by small amounts of adipose tissue and, in aggregate, weighed 20 grams. The cortices were orange-yellow and not hyperplastic. The medullae were gray-tan and unremarkable.

SPLEEN: The spleen weighed 75 grams. The capsule was purple-gray, smooth, glistening, and intact. The parenchyma was moderately firm, rubbery and dark red-brown. The red pulp and white pulp were readily demarcated. There was no infection, fibrosis, or tumor.

GENITOURINARY TRACT: The right and left kidneys weighed 100 grams and 125 grams, respectively. Both capsules stripped with ease to reveal smooth and glistening red-brown cortical surfaces. The cortices and medullae were demarcated and without focal lesions. The papillae, calyces, and pelves were unremarkable. The ureters were of normal caliber and patency. There were 50 milliliters of clear yellow urine within the urinary bladder. The mucosal surface was gray-tan and trabeculated. The prostate was of usual size, shape, and consistency. There were no nodules or other gross lesions. The testicles were unremarkable both externally and on cut sections.

GASTROINTESTINAL TRACT: The esophagus was opened along its length and had a gray-white smooth mucosa. There was extensive hemorrhage surrounding the esophagus. There was a perforating gunshot wound through the fundus of the stomach with contusions surrounding the wound margins. The stomach was opened along the greater curvature and contained 150 milliliters of thick, green-brown digestate and partially digested food. The mucosa was otherwise gray-tan. The rugal pattern was maintained. The duodenum, small intestine, and large intestine were unremarkable. The appendix was at its usual location at the tip of the cecum and was unremarkable.

BONES: There was a gunshot wound perforation and fracture of the body of the 11th thoracic vertebra. The remaining axial and appendicular skeletons were intact and unremarkable. There was a gunshot wound perforation of the left leaflet of the diaphragm. The remaining skeletal muscle was red-brown and unremarkable.

NECK: The internal structures of the neck were removed. The larynx was opened and contained minimal amounts of watery clear fluid. The mucosa was gray-pink and not congested. The hyoid bone, thyroid cartilage, and cricoid cartilage were intact and not hemorrhagic. The strap muscles were reflected and had no hemorrhages. The thyroid gland was of usual size, shape, and consistency. It was red-brown both externally and on cut surface. The tongue was serially sectioned and had no fibrosis or hemorrhage.

HEAD: The head was opened with the usual bimastoidal incision. There were no hemorrhages beneath the scalp. The calvarium was removed and had no fractures. There was no epidural, subdural, or subarachnoid hemorrhage. The brain weighed 1350 grams. The vascular structures at the base of the brain were unremarkable. The uncal processes and cerebellar tonsils were unremarkable. The relationship of gyri to sulci was within normal limits. The cerebral hemispheres were coronally sectioned. The cortical gray ribbon and deeper white matter were delineated and without hemorrhages or focal lesions. The ventricular system was of normal size, shape, and contained minimal clear cerebrospinal fluid. The basal ganglia were unremarkable. The brain stem and cerebellum were serially sectioned. There were no hemorrhages. The atlantooccipital articulation was stable. There were no neck fractures.

DESCRIPTION OF INJURY: GUNSHOT WOUND OF LEFT CHEST:
This was a penetrating gunshot entrance wound of the lateral aspect of the upper left chest, located 17 inches below the top of the head and 7 inches to the left of the anterior midline. The ovoid wound defect measured 5/8 by 3/8 inch. An eccentric marginal abrasion collar measured 1/16 inch in width superiorly. A superimposed, ovoid, 1/4 by 7/16 inch abrasion was on the superior

lateral wound margin. Faint gunpowder stippling was on the skin around the entrance wound and measured out to a distance of 2 inches from the wound margin superiorly, 1-1/2 inches from the wound margin medially, and 2 inches from the wound margin inferiorly. A 2 by 1 inch, vertically-oriented cluster of faint stippling was on the anterior aspect of the left arm. There was no soot deposition on the skin around the entrance wound. The wound path was through the skin, subcutaneous tissue and musculature of the lateral aspect of the upper left chest, the anterior lateral left 5th intercostal space, the anterior lateral aspect of the lower lobe of the left lung, the left leaflet of the diaphragm, the stomach, the thoracoabdominal aorta, the 11th thoracic vertebra, and the right lobe of the liver. A mildly deformed copper-jacketed, large caliber, hollow point bullet was recovered just beneath the right leaflet of the diaphragm. The direction of the wound path was front to back, left to right, and downward. The bullet was placed in a labeled evidence envelope and given to evidence technicians.

TOXICOLOGY: Liver, stomach contents, bile, blood, urine, and vitreous were obtained for toxicological analysis.

HISTOLOGY: Portions of the tissues were retained in formalin.

PATHOLOGICAL FINDINGS

Gunshot wound of the left chest with injury to the thoracoabdominal aorta, left lung, stomach, spinal column and liver.

OFFICE OF THE MEDICAL EXAMINER OF HARRIS COUNTY
JOSEPH A. JACHIMCZYK FORENSIC CENTER
1885 OLD SPANISH TRAIL
HOUSTON, TEXAS 77054-2098

REPORT OF ANALYSIS
December 10, 1998

TO: Roger P. Milton Jr., M.D.
Assistant Medical Examiner

CASE#: ML98-3366

Evidence submitted on 12/09/98.

RESULTS:

Blood: Ethanol, Methanol, Acetone, Isopropanol- Not Detected.

Urine: Marihuana Metabolite, Cocaine Metabolite, Phencyclidine, Amphetamine/Methamphetamine, Opiate- Not Detected.

Unless otherwise requested, specimens will be discarded one year after date of receipt.

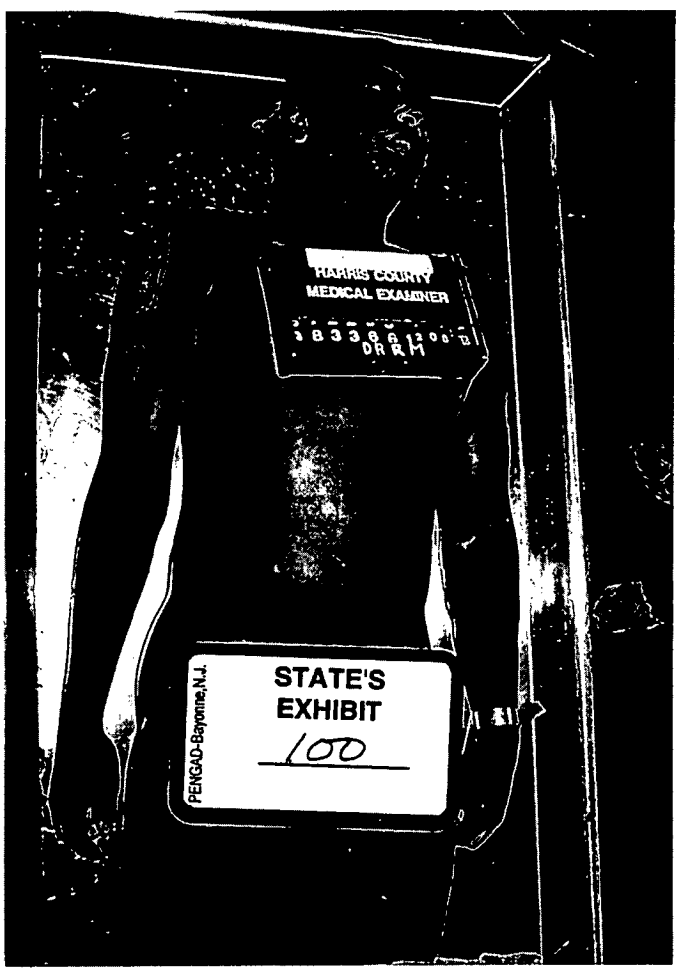
Patricia L. Small, B.S., MT, ASCP
Assistant Toxicologist

Ashraf Mozayani, Ph.D., DABFT
Chief Toxicologist

DEC 17 1998

Medical Examiner's Initial

STATE'S EXHIBIT NO. 100


HARRIS COUNTY
MEDICAL EXAMINER
DR#M
PENGAD-Bayonne,N.J.
STATE'S
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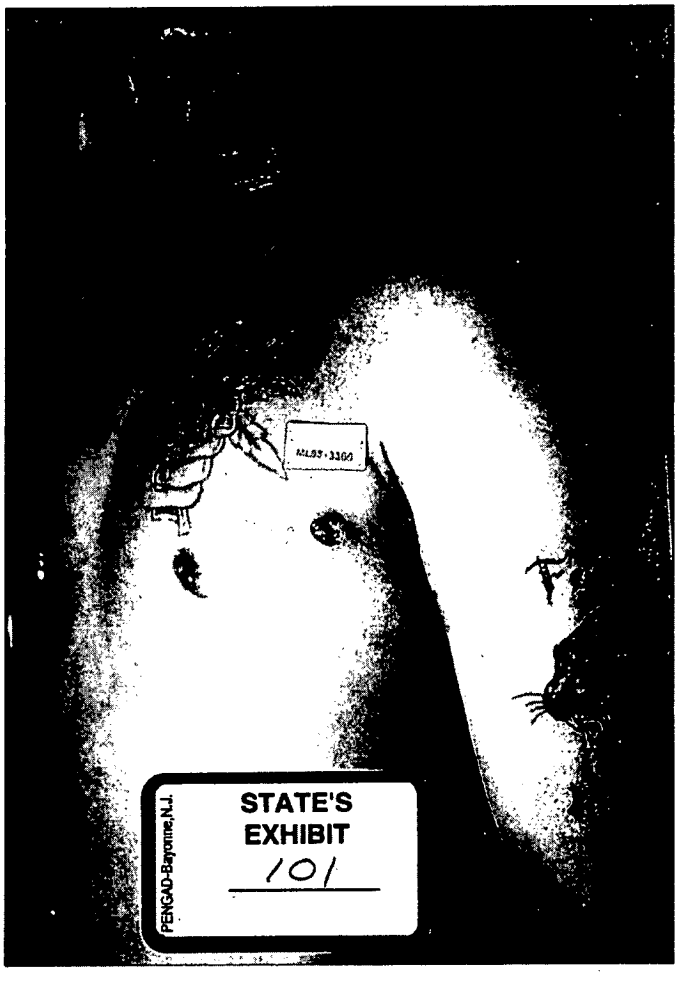
100

STATE'S EXHIBIT NO. 101


STATE'S
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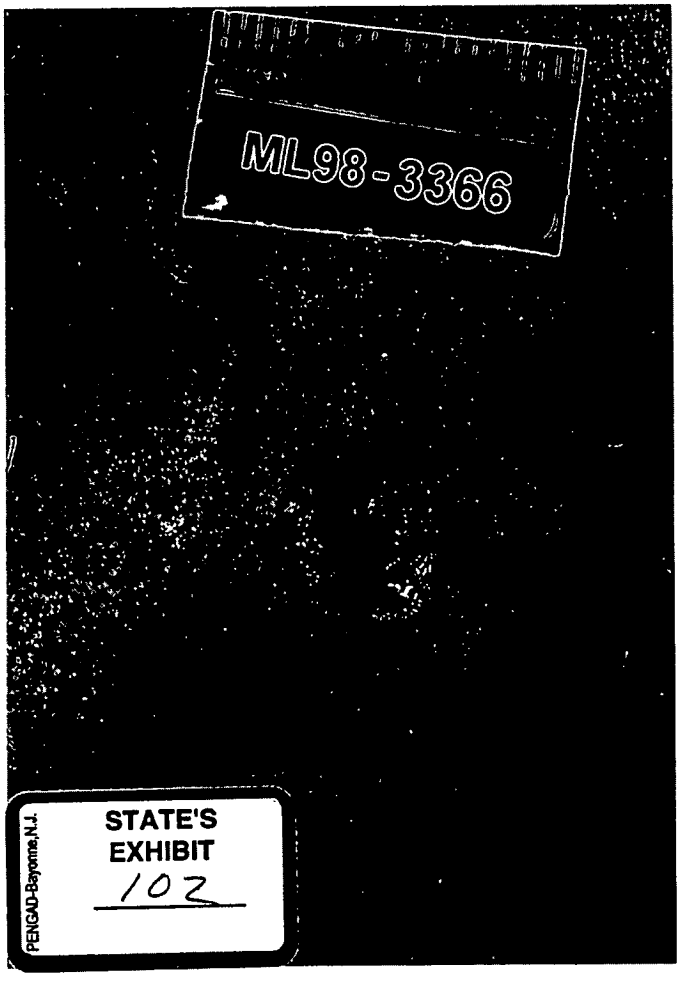
PENGAD-Bayonne, N.J.

STATE'S EXHIBIT NO. 102


ML98-3366
STATE'S
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102
PENGAD-Bayonne,N.J.

STATE'S EXHIBIT NO. 103

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OFFICE OF THE MEDICAL EXAMINER OF HARRIS COUNTY
JOSEPH A. JACHIMCZYK FORENSIC CENTER
1885 OLD SPANISH TRAIL
HOUSTON, TEXAS 77054-2098

AUTOPSY REPORT

Case 98 - 3385

December 9, 1998

ON THE BODY OF

Mary Tuana Carmouche
7425 Jay Street
Houston, Texas

CAUSE OF DEATH: Gunshot wound of chest.

MANNER OF DEATH: Homicide.

Roger F. Milton Jr. 1-25-99
Roger F. Milton Jr., M.D. Date
Assistant Medical Examiner

Reviewed and signed by:

Joye M Carter MD 2-1-99
Joye M. Carter, M.D., FCAP Date
Chief Medical Examiner

ENGAD-Bayonne,N.J.
STATE'S EXHIBIT 103

POSTMORTEM EXAMINATION ON THE BODY OF

Mary Tuana Carmouche
7425 Jay Street
Houston, Texas

HISTORY: This unidentified black female, subsequently identified as 17 year old Mary Comouche, was found dead at 9227 Lynchester, Houston, Texas, at 12:30 p.m. on December 8, 1998. See Companion Case 98 - 3366.

AUTOPSY: The autopsy was performed in the Joseph A. Jachimczyk Forensic Center of Harris County by Assistant Medical Examiner Roger P. Milton, Jr., M.D., pursuant to Article 49.25, Texas Code of Criminal Procedure, beginning at 11:30 a.m., on December 9, 1998.

CLOTHING: The body was received in a white plastic body bag. The body was clad in a red t-shirt with "TOMMY" on the front and "GIRL" on the back; blue jeans with a black, woven, leather belt; silver and blue-gray Nike tennis shoes with red shoestrings; gray panties; and white socks. A gold medallion of "M" was around the neck on a gold chain. The right and left superior aspects of the ear pinnae had gold stud earrings. There was a perforation on the front of the shirt, surrounded by a thin ring of dirt.

EVIDENCE OF MEDICAL INTERVENTION: None.

EXTERNAL APPEARANCE: The body was that of a well developed, well nourished, black female who measured 61 inches and weighed 108 pounds, appearing compatible with the stated age of 17 years. Minimal rigor mortis remained in the extremities and the jaw. Purple fixed livor mortis was on the anterior surface of the body, except in areas exposed to pressure. There was faint unfixed livor mortis on the posterior surface of the body, except in areas exposed to pressure. The head was symmetrical and covered with curly, red-gold hair, measuring 9 inches over the crown. The irides were brown and the pupils were bilaterally dilated to 4 millimeters. The sclerae were clear. The conjunctivae were markedly congested. The corneae were mildly cloudy. There were a few petechial hemorrhages in the lower right conjunctiva. The anterior central aspect of the face showed purple fixed livor mortis. A 1-1/2 by 3/4 inch cluster of excoriations, consistent with insect activity, was on the superolateral right periorbital region, measuring up to 3/8 by 3/16 inch. The right supraorbital region had a 1/8 by 1/16 inch abrasion. The anterior left forehead had a 2-1/4 by 3/4 inch cluster of irregularly shaped abrasions, measuring up to 3/16 inch by 1/8 inch. The left forehead had a 1/8 by 1/32 inch abrasion. A 1/4 by 3/16 inch abrasion was on the left anterior bridge of the nose. A 1/8 by 1/16 inch abrasion was on the medial left infraorbital region. The lower half of the right

side of the nose had a 1 by 1/2 inch cluster of excoriations, consistent with insect activity, measuring up to 3/16 by 1/8 inch. Natural teeth were in good condition in the oral cavity. The left corner of the upper lip and left corner of the lower lip had excoriations, consistent with insect activity, measuring 1/4 by 1/8 inch and 3/8 by 1/8 inch, respectively. The anterior chin had a 1/2 by 1/2 inch cluster of punctate excoriations, consistent with insect activity, measuring up to 1/8 by 1/8 inch. The left side of the neck had a 3/8 by 1/8 inch cluster of excoriations, consistent with insect activity. The anterior and right side of the neck had hyperpigmented patches of dried skin. Two, 1/8 by 1/16 inch scabs were on the inferior left side of the posterior neck. The right and left earlobes were pierced and the superior aspect of the right and left ear pinnae were pierced once. There was a gunshot entrance wound on the anterior medial right chest. A 1/16 inch abrasion was located 2 inches to the right of the gunshot entrance wound. The anterior chest showed no additional palpable masses or scars. The abdomen was flat to scaphoid and covered with sparse body hair. A 1-1/2 by 3/8 inch cluster of excoriations, consistent with insect activity, were on the right side of the abdomen. Additional excoriations, consistent with insect activity, were on the right lower quadrant of the abdomen and anterior right hip region, measuring up to 1/2 by 1/8 inch. A 1-1/2 by 1/2 inch cluster of postmortem excoriations with a superimposed linear 1-1/2 by 1/16 inch, postmortem excoriation was on the lateral right hip region. The pubic hair was moderately abundant and partially shaved. The genitalia were those of a normal adult female. The right and left lower extremities showed multiple well healed scars of the right and left knees and legs. A 3 by 3 inch tattoo of a star reading "SUPERSTAR" was on the anterior dorsal right foot. The dorsal aspect of the right forearm had a 2-1/2 by 1/32 to 1/16 inch superficial cutting wound with a superimposed 1/4 by 3/16 inch cluster of postmortem excoriations. The posterolateral right upper extremity, the dorsal right and left hands, and dorsal left forearm showed multiple irregular excoriations, consistent with postmortem insect activity. The appropriate number of digits were on the hands and feet. The fingernails and toenails were painted with silver metallic polish. There were patchy areas of hyperpigmented, slightly roughened skin on the anterior neck, lateral aspects of the chest, back, abdomen, and hips. There was a 1-1/2 by 1-1/2 inch tattoo of a butterfly on the superolateral left side of the upper back. A few excoriations, consistent with insect activity, were on the left and right lateral aspects of the lower back. A bullet was palpable beneath the skin of the right lower back. The anus, perineum, and back were otherwise unremarkable.

INTERNAL EXAMINATION: Section: The chest and abdomen were opened by the usual Y-shaped incision. The abdominal fat layer at the level of the umbilicus measured 3/4 inch in maximum thickness. The chest plate was removed. A bullet perforation and fracture of the

anteromedial aspect of the right 5th rib was noted. Eleven hundred milliliters of blood were in the right pleural cavity. The peritoneal and left pleural cavities contained no excess fluid. The peritoneal and pleural surfaces were otherwise smooth and glistening. The internal organs were in their usual locations and had normal anatomic relationships to one another.

HEART: The pericardial sac was opened and contained 75 milliliters of liquid and clotted blood. The heart weighed 175 grams. A 1 inch, vertically oriented, grazing laceration was on the anterolateral aspect of the right atrium of the heart. The proximal aspect of the inferior vena cava was perforated. The epicardium and myocardium surrounding the laceration was hemorrhagic. The epicardium was otherwise gray-brown, smooth, and glistening. The coronary arteries arose in the usual locations and were normally located over the surface of the heart. There was no atherosclerosis. The myocardium was otherwise red-brown and had no additional lesions, nodules, or fibrosis. The right and left ventricles were of normal size and configuration. The cardiac valve cusps and leaflets were normal in number and configuration. There was no atherosclerosis of the aortic root. The interventricular septum was intact.

LUNGS: The right and left lungs weighed 175 grams and 200 grams, respectively. A perforating wound track with surrounding contusion was on the medial inferior aspect of the middle lobe of the right lung. The medial inferior aspect of the lower lobe of the right lung showed contusion. The bronchi were opened to the bronchioles and contained minimal, blood-tinged, watery fluid. The mucosa was yellow-tan and not congested. The uninjured pleural surfaces were pink, smooth, glistening, and intact. There was no anthracotic pigment deposition. The parenchyma was soft. There was mild congestion in all lobes. There were no additional lesions, tumors, infection, or cavitation noted.

LIVER: The liver weighed 775 grams. A 1/2 by 1/2 inch graze wound was on the superior medial right lobe of the liver with surrounding subcapsular hemorrhage. The capsule was otherwise smooth, glistening, red-brown, and intact. The parenchyma was mildly to moderately firm, red-brown, and otherwise unremarkable. The gallbladder contained 20 milliliters of bile. There were no gallstones. The hepatobiliary ducts were patent.

Pancreas: The pancreas weighed 50 grams. The external and cut surfaces were gray-tan. There were no nodules or other gross lesions.

Adrenals: The adrenal glands were surrounded by mild amounts of adipose tissue and, in aggregate, weighed 15 grams. The cortices

were orange-yellow and not hyperplastic. The medullae were gray-tan and unremarkable.

SPLEEN: The spleen weighed 75 grams. The capsule was purple-gray, smooth and glistening, and intact. The parenchyma was moderately firm, rubbery, and dark red-brown. The red pulp and white pulp were readily demarcated. There was no infection, fibrosis, or tumor.

GENITOURINARY TRACT: The right and left kidneys weighed 75 grams each. Both capsules stripped with ease to reveal smooth and glistening red-brown cortical surfaces. The cortices and medullae were demarcated and without focal lesions. The papillae, calyces, and pelves were unremarkable. The ureters were of normal caliber and patency. There were 150 milliliters of clear yellow urine within the urinary bladder. The mucosal surface was gray-tan and trabeculated. The uterus and adnexal structures were intact and unremarkable. The cervical os was slit-like and unremarkable. The endometrium was brown-tan and not thickened.

GASTROINTESTINAL TRACT: The esophagus was opened along its length and had a gray-white mucosa. The stomach was opened along the greater curvature and contained 50 milliliters of pasty brown digestate. The mucosa was gray-tan. The rugal pattern was slightly maintained. The duodenum, small intestine, and large intestine were unremarkable. The appendix was at its usual location at the tip of the cecum and was unremarkable.

BONES: The anterior medial aspect of the right 5th rib was fractured. There was a fracture and bullet perforation of the right side of the body of 11th thoracic vertebra. The remaining axial and appendicular skeletons were intact and unremarkable. The medial aspect of the right leaflet of the diaphragm was perforated. The skeletal muscle was red-brown and otherwise unremarkable.

NECK: The internal structures of the neck were removed. The larynx was opened and contained minimal amounts of watery clear fluid. The mucosa was gray-pink and not congested. The hyoid bone, thyroid cartilage, and cricoid cartilage were intact and not hemorrhagic. The strap muscles were reflected and had no hemorrhages. The thyroid gland was of usual size, shape, and consistency. It was red-brown both externally and on cut surface. The tongue was serially sectioned and had no fibrosis or hemorrhage.

HEAD: The head was opened with the usual bimastoidal incision. There were no hemorrhages beneath the scalp. The calvarium was removed and had no fractures. There was no epidural, subdural, or subarachnoid hemorrhage. The brain weighed 1350 grams. The

vascular structures at the base of the brain were unremarkable. The uncal processes and cerebellar tonsils were unremarkable. The relationship of gyri to sulci was within normal limits. The cerebral hemispheres were coronally sectioned. The cortical gray ribbon and deeper white matter were delineated and without hemorrhages or focal lesions. The ventricular system was of normal size, shape, and contained minimal clear cerebrospinal fluid. The basal ganglia were unremarkable. The brain stem and cerebellum were serially sectioned. There were no hemorrhages. The atlantooccipital articulation was stable. There were no neck fractures.

DESCRIPTION OF INJURY: Gunshot wound of chest. There was a penetrating gunshot entrance wound of the anteromedial right chest, located 13-1/2 inches below the top of the head and 1 inch right of the anterior midline. The vertically oriented, ovoid wound measured 9/16 by 1/4 inch. There was no evidence of soot deposition or gunpowder stippling on the skin around the entrance wound. An eccentric marginal abrasion collar measured up to 1/4 inch in width at the 11 o'clock position of the wound margin and up to 1/16 inch in width at the 1 o'clock position of the wound margin. The wound path was through the skin, subcutaneous tissue, and musculature of the anteromedial right chest, the anteromedial aspect of the right 5th rib, the anteromedial aspect of the middle lobe of the right lung, the pericardial sac and right atrium of the heart, the inferior vena cava, the medial aspect of the right leaflet of the diaphragm, the superomedial aspect of the right lobe of the liver, the anterolateral right side of the 11th thoracic vertebra, the right-sided paraspinal muscles and the subcutaneous tissue of the medial aspect of the right side of the back. A mildly deformed, fully metal jacketed, large caliber bullet was recovered from the subcutaneous tissue of the medial right side of the back, 17 inches below the top of the head. The bullet was placed in a labeled evidence envelope and given to Evidence Technicians. The direction of the gunshot wound path was front to back, downward, and slightly right to left. Associated injuries have been previously described.

TOXICOLOGY: Liver, stomach contents, bile, blood, urine, and vitreous were obtained for toxicological analysis.

HISTOLOGY: Portions of the tissues were retained in formalin.

PATHOLOGICAL FINDINGS

1. Gunshot wound of the chest.
2. Injury to the right atrium of the heart, right lung, diaphragm, liver, right 5th rib, and 11th thoracic vertebra.

OFFICE OF THE MEDICAL EXAMINER OF HARRIS COUNTY
JOSEPH A. JACHIMCZYK FORENSIC CENTER
1885 OLD SPANISH TRAIL
HOUSTON, TEXAS 77054-2098

REPORT OF ANALYSIS

December 10, 1998

TO: Roger P. Milton Jr., M.D.
Assistant Medical Examiner

CASE#: ML98-~~3285~~ 3385

Evidence submitted on 12/10/98.

RESULTS:

Blood: Ethanol, Methanol, Acetone, Isopropanol- Not Detected.

Urine: Marihuana Metabolite, Cocaine Metabolite, Amphetamine/Methamphetamine, Phencyclidine, Opiate- Not Detected.

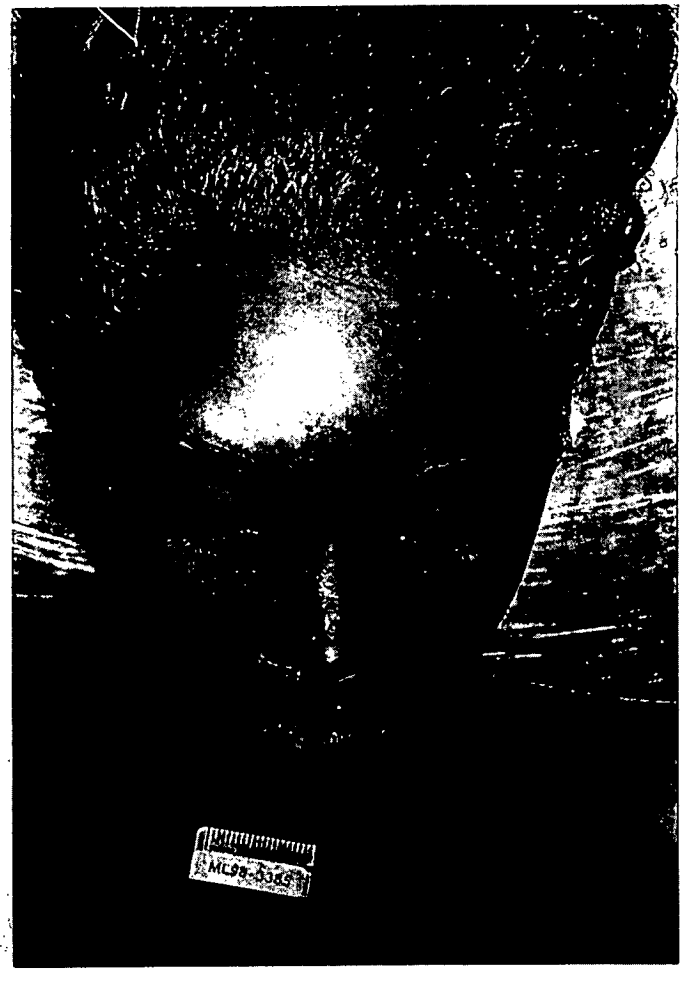
Unless otherwise requested, specimens will be discarded one year after date of receipt.

Patricia L. Small, B.S., MT, ASCP
Assistant Toxicologist

Ashraf Mozayani, Ph.D., DABFT
Chief Toxicologist

Medical Examiner's Initial

STATE'S EXHIBIT NO. 104



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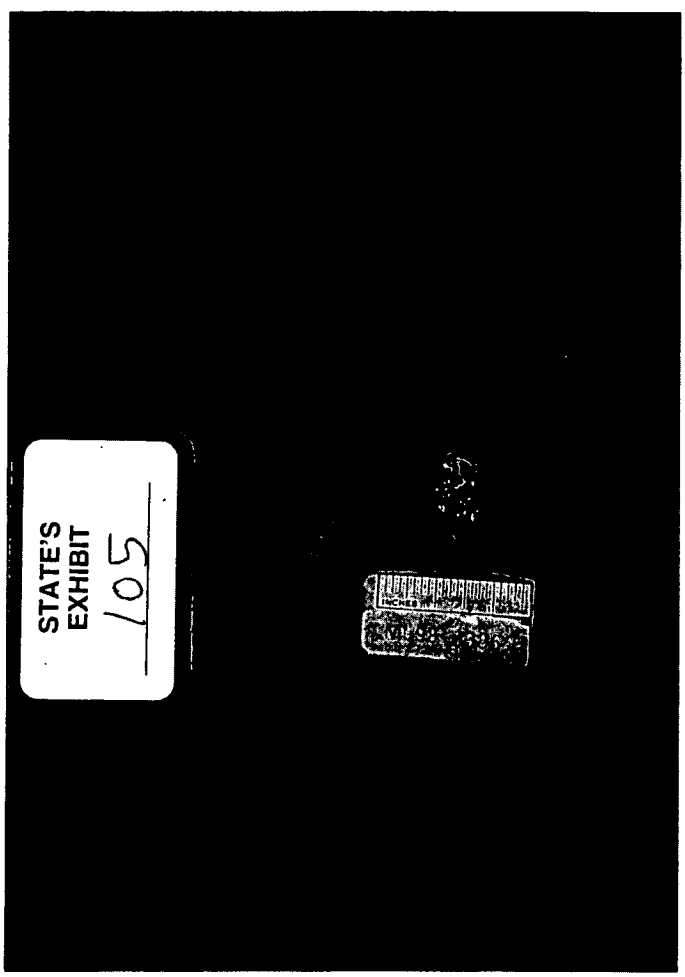
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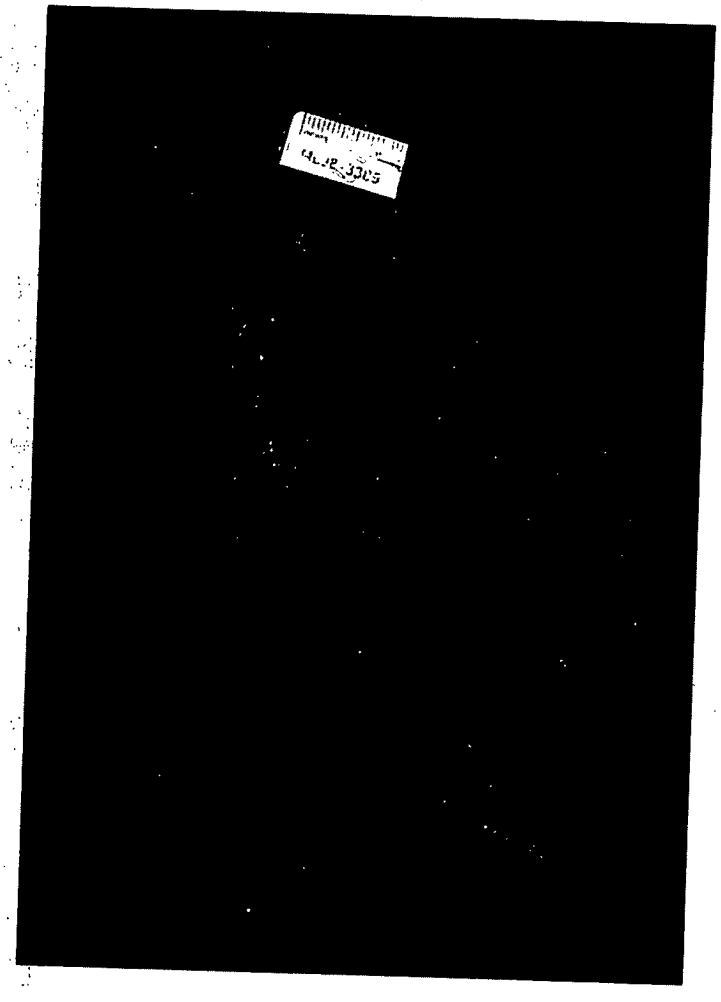

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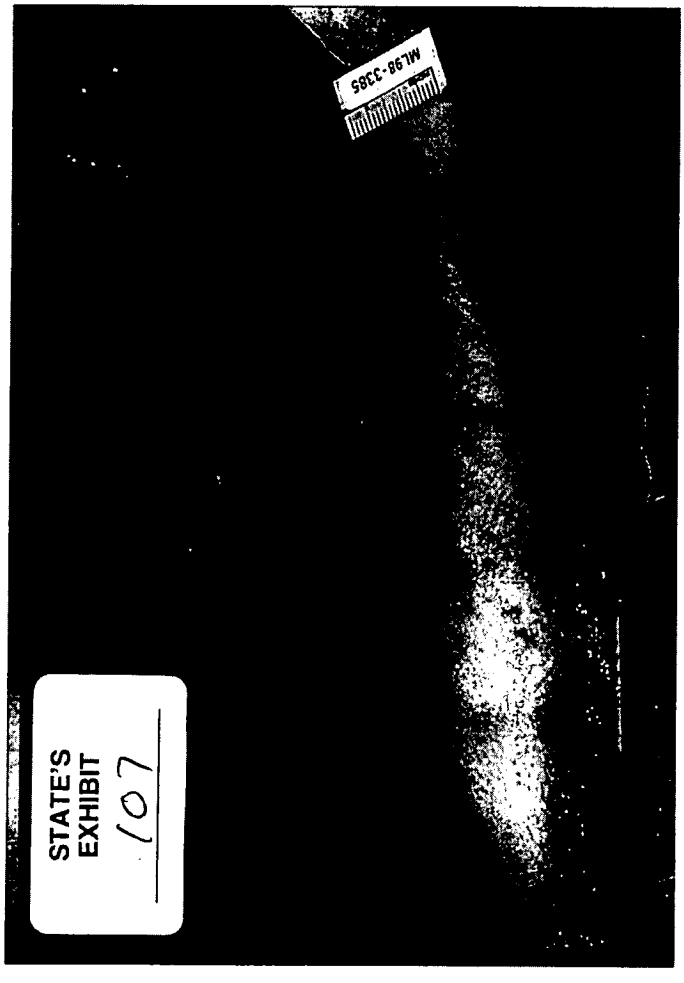
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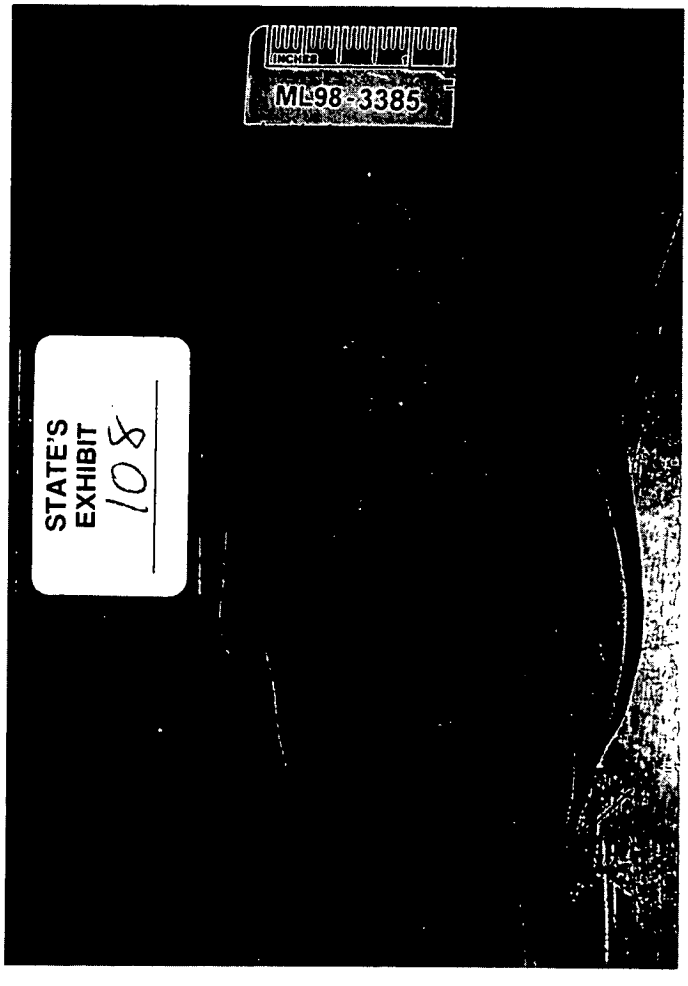
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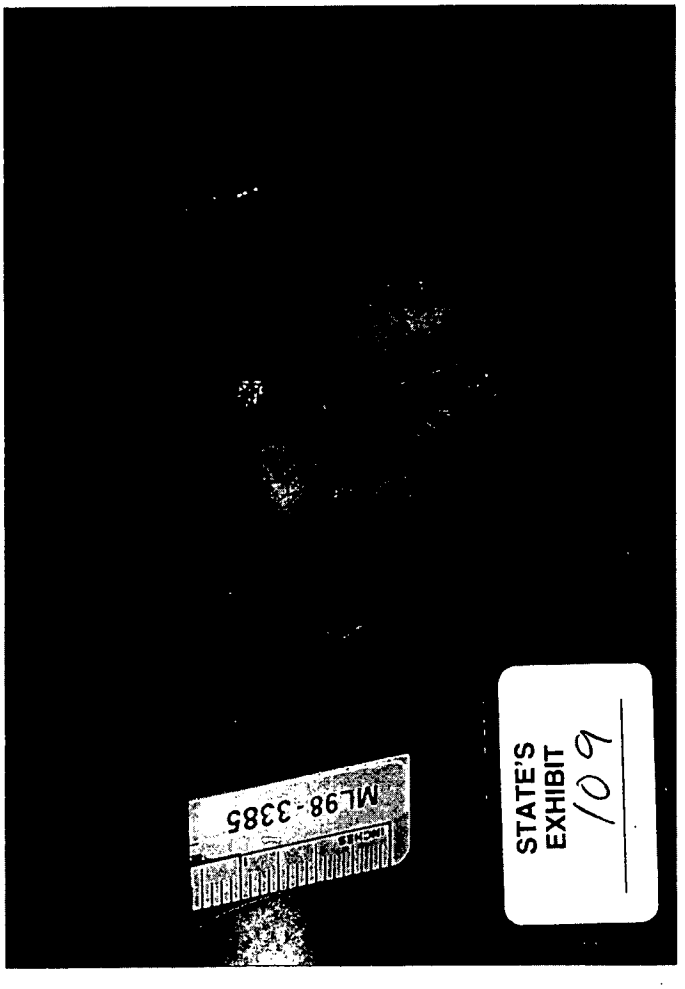
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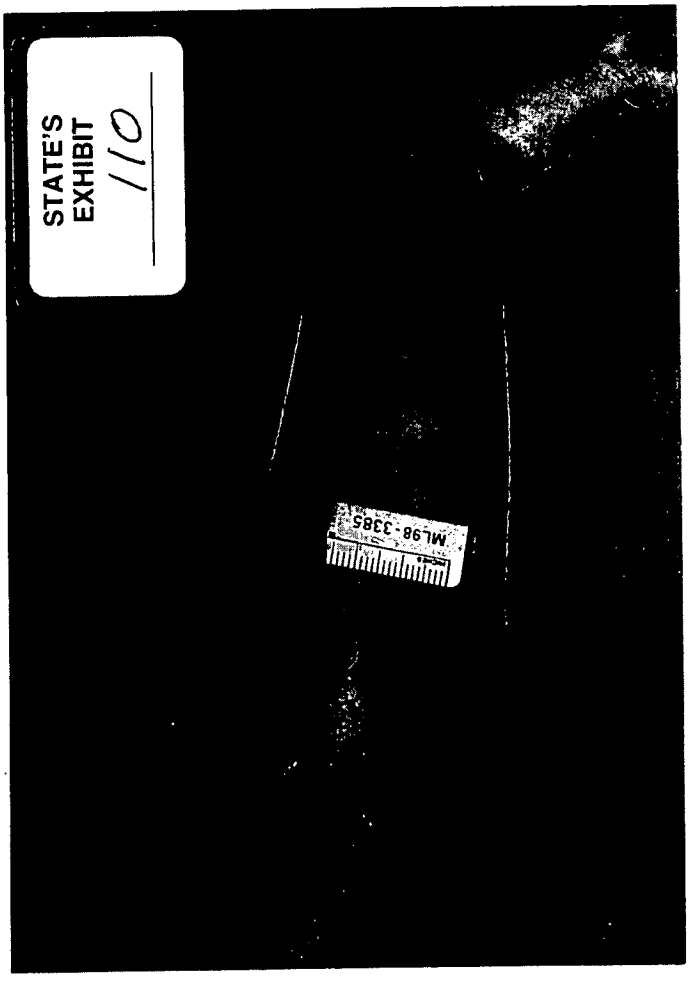
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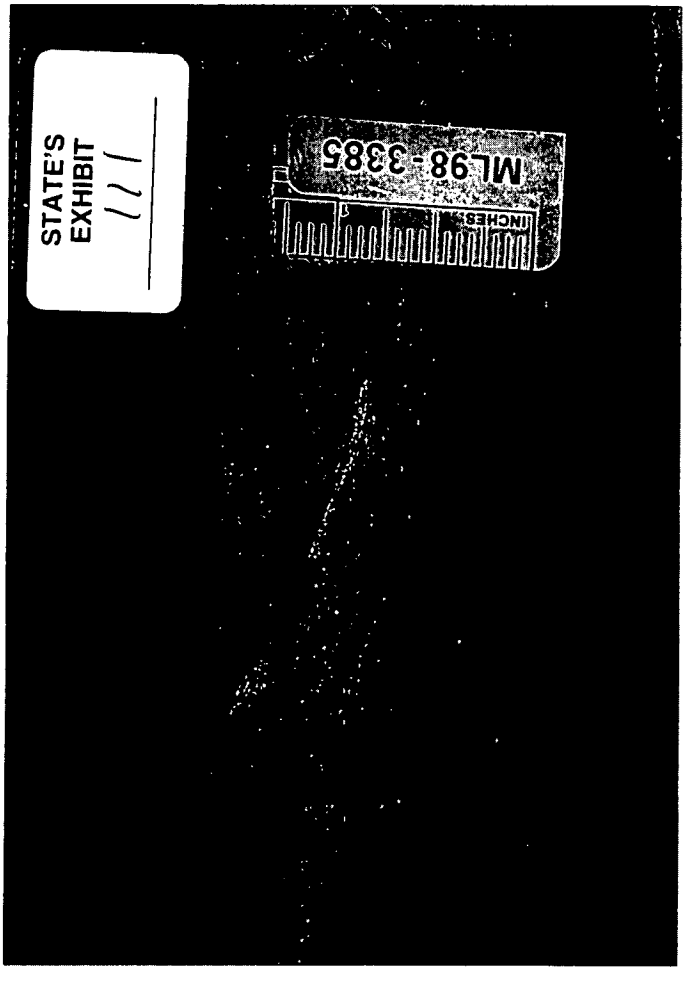
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STATE'S EXHIBIT NO. 112

Division - C
Alonzo Harris - 1

Friday, February 19, 1999

Court met pursuant to adjournment, Present, His Honor, Alonzo Harris, Judge presiding; Laura Noel, Court Reporter; Cynthia Fontenot, Deputy Minute Clerk; Shaunn Callier and Randy Wagley, Assistant District Attorneys; Calvin Moore, Asst. Warden; Rodney Lazard, Bailiff; all being in attendance.

94-4627C

STATE OF LOUISIANA
VS
CHARLES HAROLD MAMOU JR
548 MLK DRIVE
SUNSET, LA
12/06/1974
461-15-3351
B/M

Defendant present with GLENN MARCANTEL for a revocation hearing. The State is represented by SHAUNN CALLIER, and the probation officer, CHRIS SMITH, is present. The Court finds that the defendant has violated the conditions of his probation and revokes same. The defendant is ordered to serve the original sentence previously imposed. The defendant is consign to the Department of Corrections, so said sentence be carried out.

Court then adjourned without date.

Approved:

/S/ Alonzo Harris

J U D G E

A TRUE AND CORRECT EXTRACT OF THE MINUTES

DEPUTY CLERK

STATE'S EXHIBIT 112

Division - C
Alonzo Harris - 1

Friday, October 20, 1995

Court met pursuant to adjournment, present, His Honor, Alonzo Harris, Judge; Angelia Bellard, Court Reporter; Wilda Drawsand, Deputy Clerk of Court; David Miller and Robert Voitier, Assistant District Attorneys; and Claudell Landry, Bailiff; all being in attendance.

94-4627C STATE OF LOUISIANA
VS
CHARLES HAROLD MAMOU JR

Defendant present with his attorney, Glenn Marcantel, for sentencing. The State is represented by David Miller, ADA. The defendant previously entered a plea of guilty to Possession with the intent to distribute cocaine. The Court received the pre-sentence report and made it available to counsel for review.

Considering the Pre-sentence Investigation, the Court will sentence the defendant to serve five (5) years at hard labor, suspended and placed on Active Supervised Probation for three and one-half (3 1/2) years under all the conditions of Article 895 of the Code of Criminal Procedure. Special conditions: pay costs; reimburse the Indigent Defender Board $150.00; pay a supervision fee of $20.00 a month; submit to random drug screenings; seek active employment in the field he is certified in; attend fellowship meetings on Mondays at Opelousas City Hall beginning October 23, 1995 at 7:00 p.m.; and serve sixty (60) days in the parish jail, credit for time served (to be set up through the probation officer). The Court advised the defendant of his rights to seek post conviction relief.

Court then adjourned without date.

Approved:

/S/ Alonzo Harris
JUDGE

A TRUE AND CORRECT EXTRACT OF THE MINUTES

Wilda Drawsand
DEPUTY CLERK

Division - C
Alonzo Harris - 1

Thursday, May 25, 1995

Court met pursuant to adjournment, present, His Honor, Alonzo Harris, Judge; Laura Noel, Court Reporter; Charles Del Bueno, Bailiff; Gary Tromblay, Assistant District Attorney; and Wilda Drawsand, Deputy Clerk of Court.

94-4627C

STATE OF LOUISIANA
VS
CHARLES HAROLD MAMOU JR
548 MLK DRIVE
SUNSET, LA
12/06/1974
461-15-3351
B/M

Defendant present with his attorney, Glenn Marcantel. Mr. Marcantel informed the Court that the defendant wish to withdraw former plea of not guilty and enter a plea of guilty to:

Possession with the intent to distribute cocaine.

Prior to permitting the said not guilty plea to be withdrawn and the guilty plea entered, the Court interrogated the defendant at length and after having satisfied itself that the defendant was fully cognizant of defendant's rights and knew the seriousness of entering a plea in this matter and that the defendant was ably and capably represented by counsel, the Court will now accept the guilty plea to:

Possession with the intent to distribute cocaine.

The Court orders a written Pre-Sentence Investigation Report returnable August 10, 1995. Sentencing is fixed for August 18, 1995 at 9:00 a.m.

Court then adjourned without date.

Approved:

/S/ Alonzo Harris

J U D G E

A TRUE AND CORRECT EXTRACT OF THE MINUTES

DEPUTY CLERK

THE STATE OF LOUISIANA
PARISH OF ST. LANDRY

BE IT REMEMBERED, That on the 18th day of January, A.D., 19 95, (leave of the Court first had and obtained) **MORGAN J. GOUDEAU, III,** District Attorney of the 27th Judicial District of the State of Louisiana, prosecuting in said capacity, for and in the name and by the authority of said State, within and for the District aforesaid, in his own proper person, comes into the Court of said District holden in and for the Parish of St. Landry, and here gives the court to understand and be informed that

CHARLES MAMOU, JR.

at the Parish of St. Landry on or about the 19th day of November in the year of our Lord, one thousand nine hundred and Ninety-four (1994)

did unlawfully, knowingly and intentionally possess with the intent to distribute a controlled dangerous substance, to-wit: Cocaine, classified as a controlled dangerous substance in Schedule II of R. S. 40:964A(4), in violation of R. S. 40:979 and 40:967A(1),

contrary to the form of the Statue of the State of Louisiana, in such cases made and provided in contempt of the authority of said State, and against the peace and dignity of the same.

Morgan J. Goudeau, III, District Attorney,
27th Judicial District Court of Louisiana

94-K-4627-C

Filed Jan. 20, 1995
Dy. Clerk

A TRUE COPY
Dy. Clerk

STATE'S EXHIBIT NO. 113

(ARREST WARRANT)

NOT ADMITTED

THE STATE OF LOUISIANA

PARISH OF ST. LANDRY

BE IT REMEMBERED, That on the 18th day of January, A.D., 19 95, (leave of the Court first had and obtained) **MORGAN J. GOUDEAU, III,** District Attorney of the 27th Judicial District of the State of Louisiana, prosecuting in said capacity, for and in the name and by the authority of said State, within and for the District aforesaid, in his own proper person, comes into the Court of said District holden in and for the Parish of St. Landry, and here gives the court to understand and be informed that

CHARLES MAMOU, JR.

at the Parish of St. Landry on or about the 19th day of November in the year of our Lord, one thousand nine hundred and Ninety-four (1994)

did unlawfully, knowingly and intentionally possess with the intent to distribute a controlled dangerous substance, to-wit: Cocaine, classified as a controlled dangerous substance in Schedule II of R. S. 40:964A(4), in violation of R. S. 40:979 and 40:967A(1),

contrary to the form of the Statue of the State of Louisiana, in such cases made and provided in contempt of the authority of said State, and against the peace and dignity of the same.

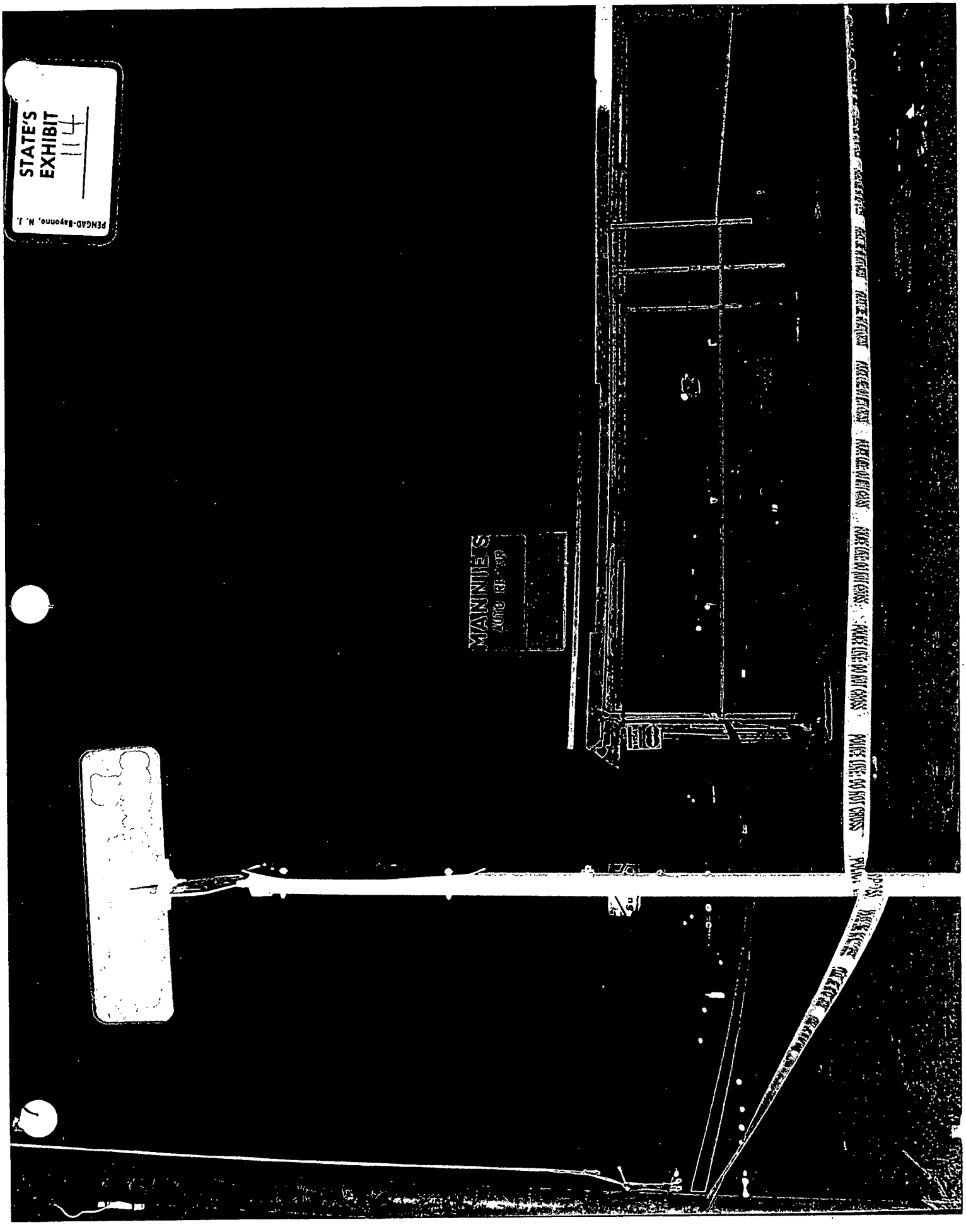
Morgan J. Goudeau, III, District Attorney,
27th Judicial District Court of Louisiana

94-K-4627-C

Filed Jan. 20 1995
Dy. Clerk

A TRUE COPY
Dy. Clerk

STATE'S EXHIBIT NO. 114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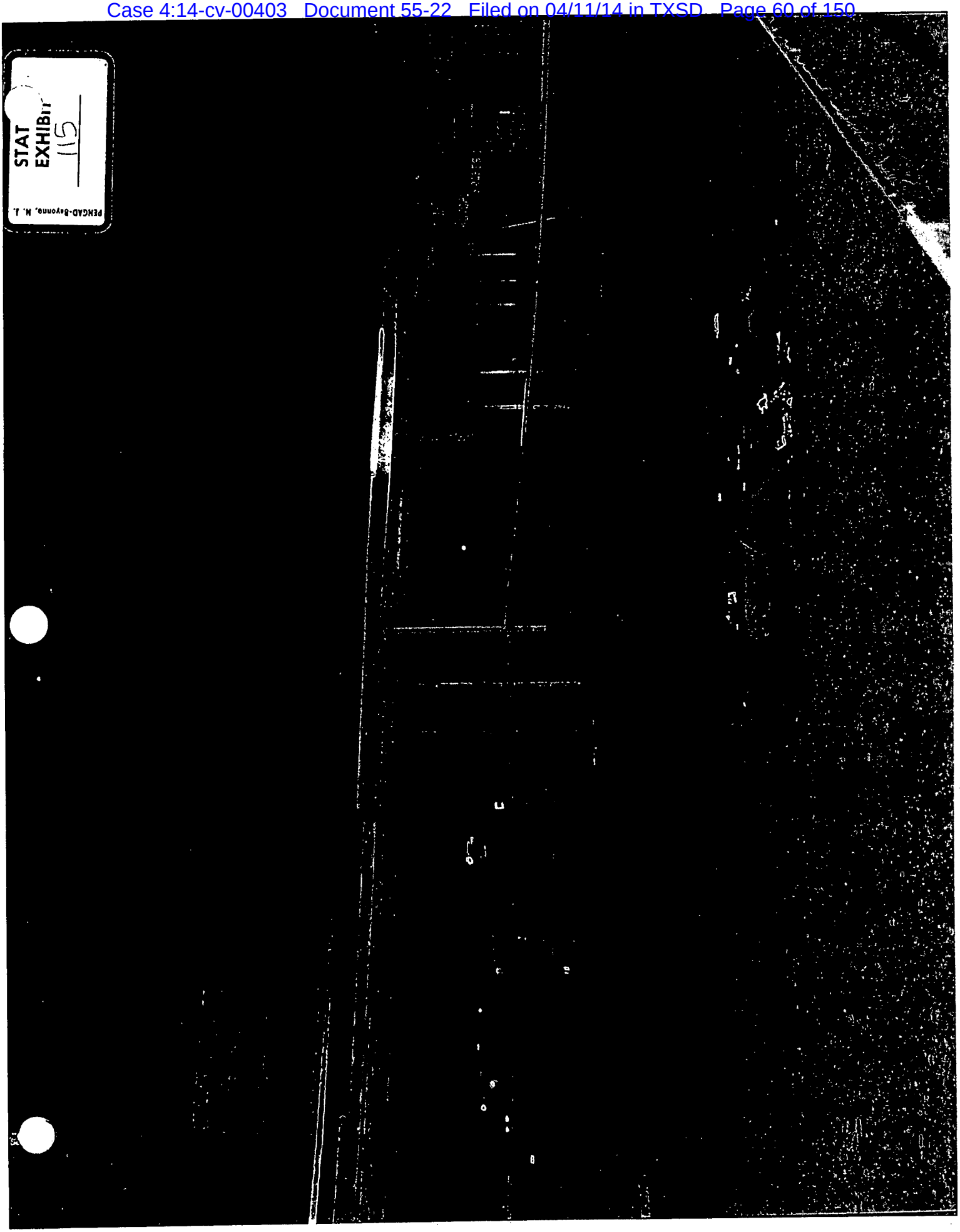
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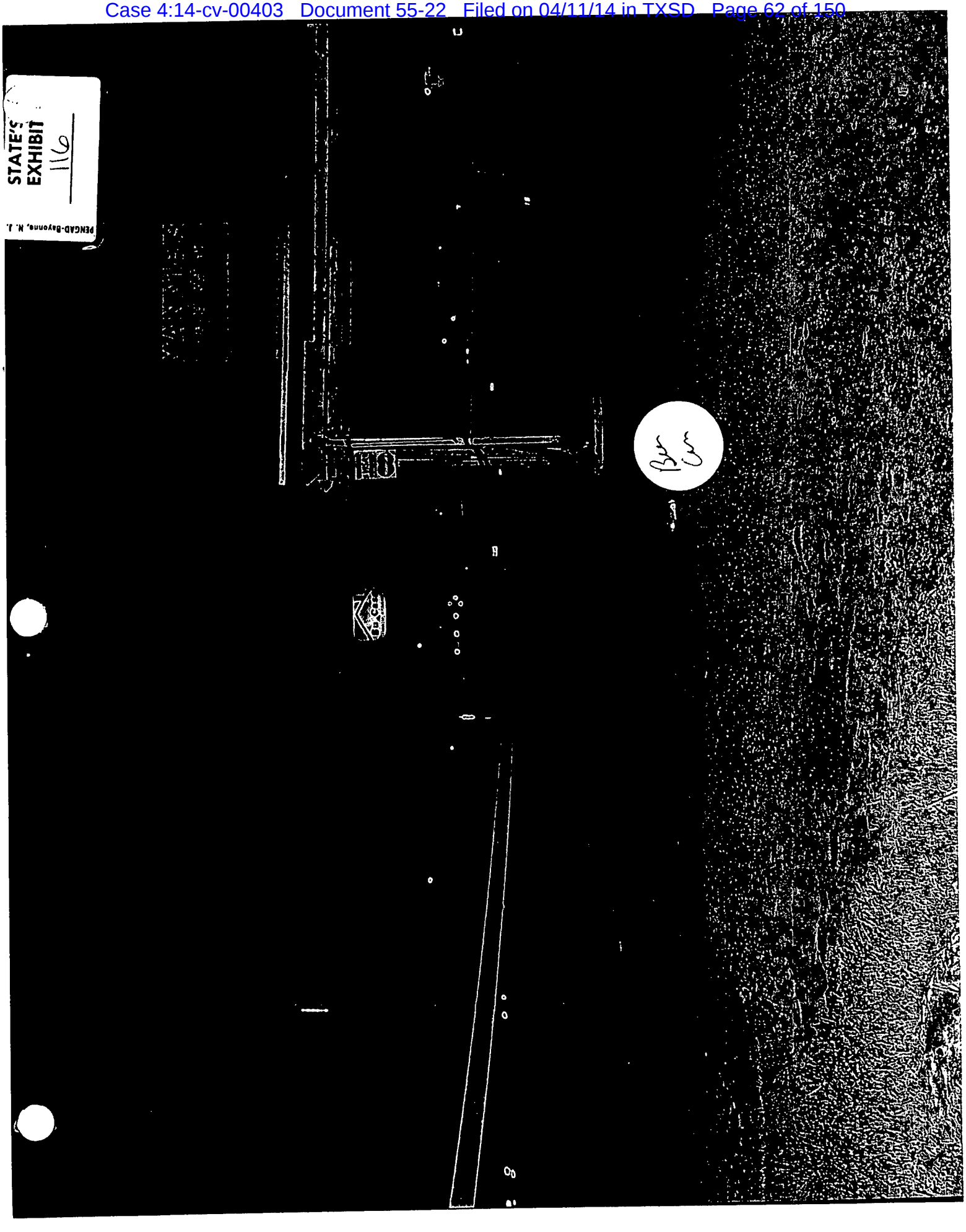
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PENCAD-Bayonne, N. J.

STATE'S EXHIBIT 117

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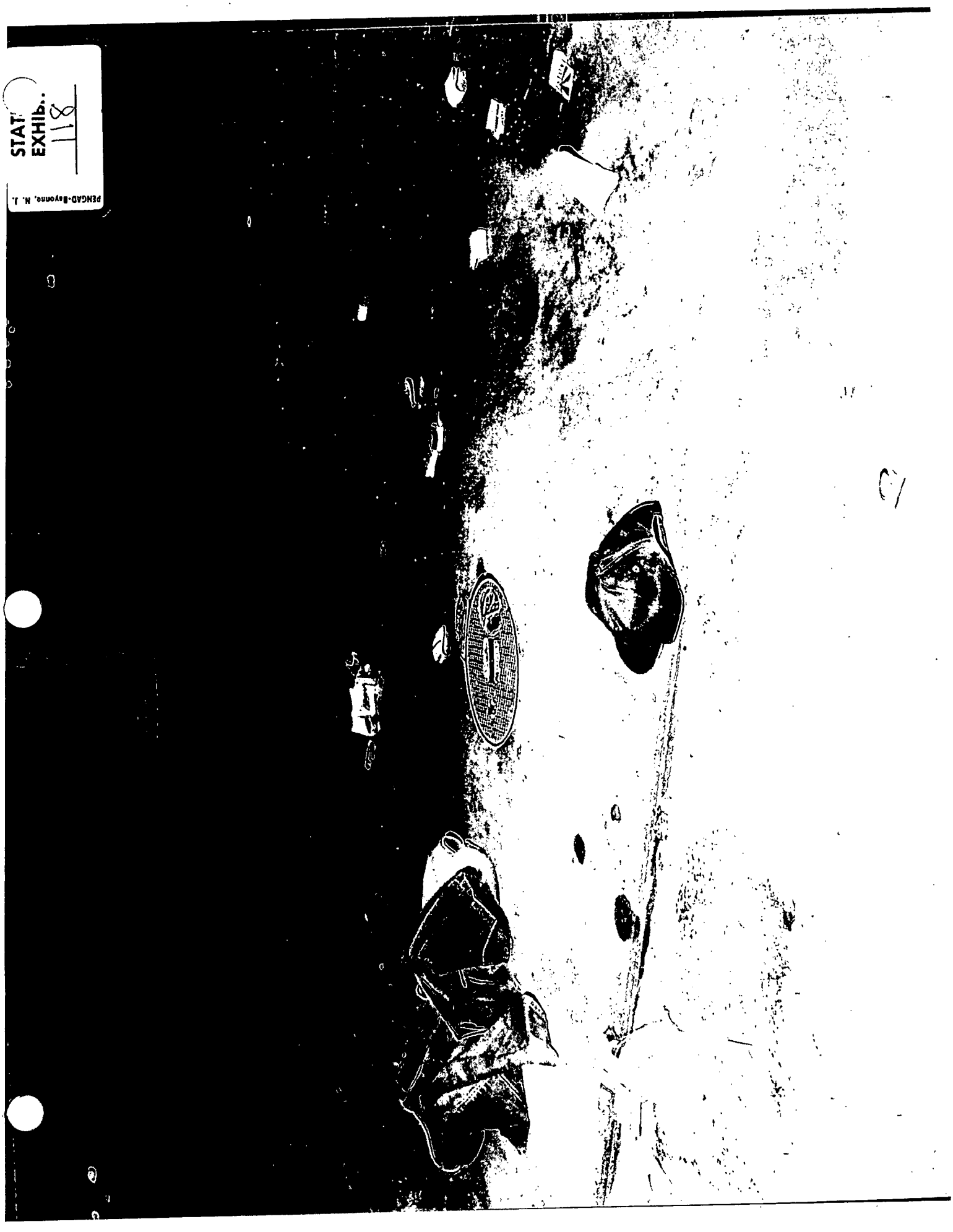
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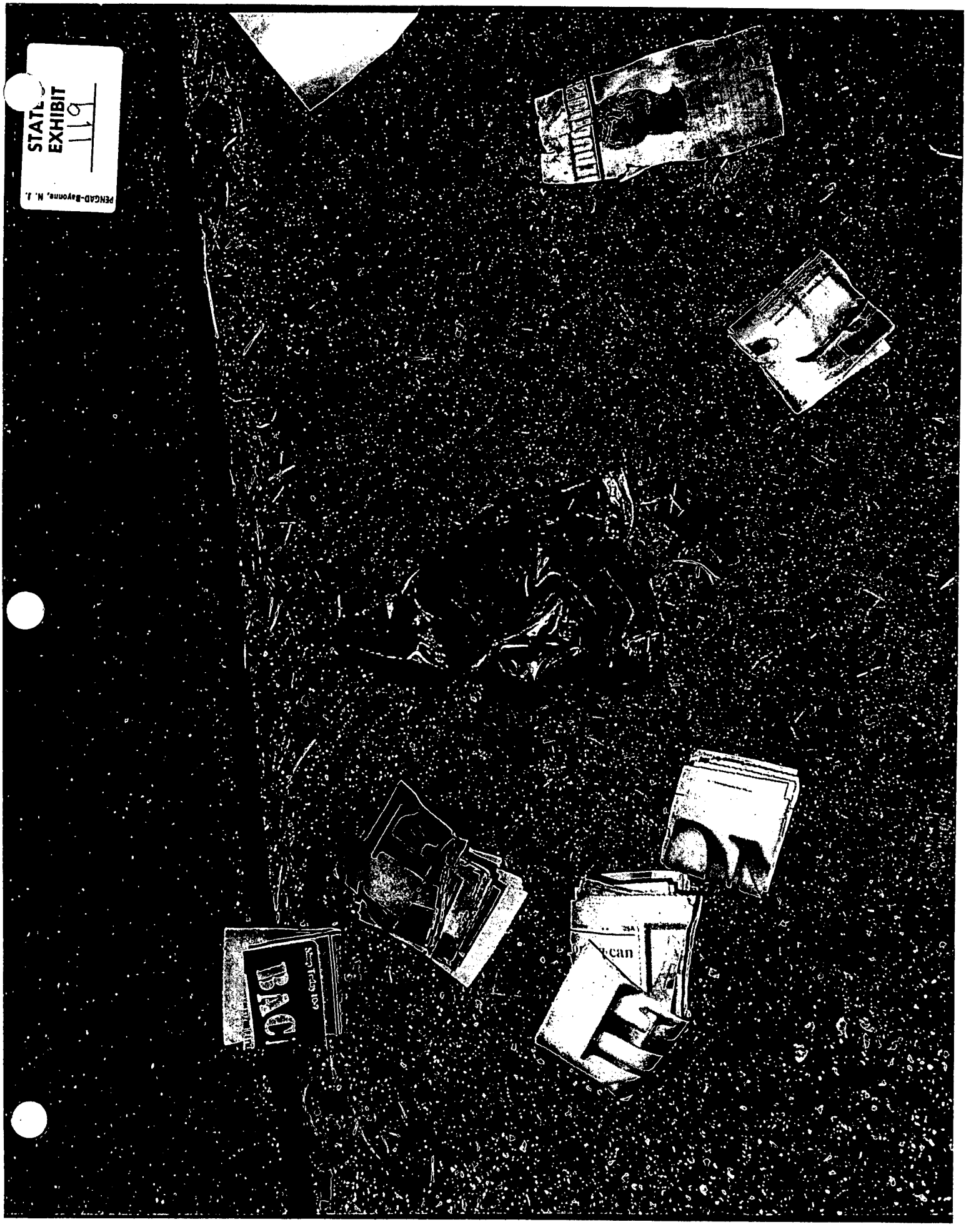
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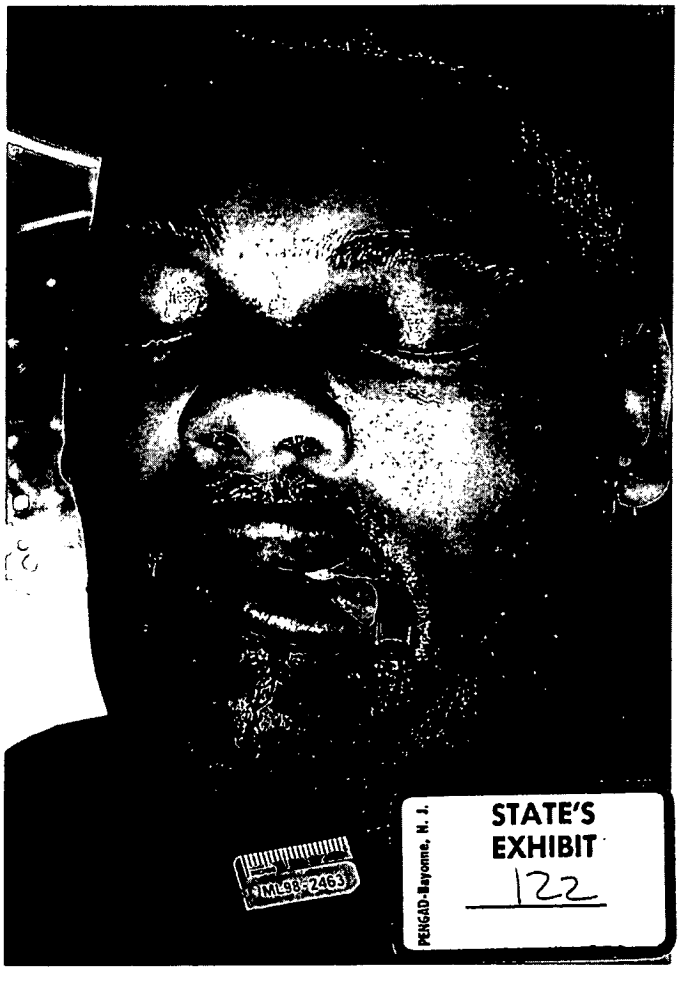
STATE'S EXHIBIT NO. 120

(NOTE: PHYSICAL EVIDENCE, SCENE VIDEO, IN THE CUSTODY OF THE DISTRICT CLERK'S OFFICE.)

STATE'S EXHIBIT NO. 121

STATE'S EXHIBIT NO. 122


PMI-98-2463
PENGAD-Bayonne, N. J.
STATE'S
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122

Joye M. Carter, M.D., FCAP
Chief Medical Examiner

(713) 796-9292
(713) 796-6815
FAX: (713) 796-6842

OFFICE OF THE MEDICAL EXAMINER OF HARRIS COUNTY
JOSEPH A. JACHIMCZYK FORENSIC CENTER
1885 OLD SPANISH TRAIL
HOUSTON, TEXAS 77054-2098

AUTOPSY REPORT

Case 98 - 2463

September 6, 1998

ON THE BODY OF

Anthony Roy Williams
14502 Castle Ridge
Houston, Texas

CAUSE OF DEATH: Penetrating gunshot wound to lower back.

MANNER OF DEATH: Homicide.

Joye M Carter MD 24 Sept 98

Joye M. Carter, M.D., FCAP — Date
Chief Medical Examiner

STATE'S EXHIBIT 121

POSTMORTEM EXAMINATION ON THE BODY OF

Anthony Roy Williams
14502 Castle Ridge
Houston, Texas

HISTORY: This 27 year old, black male was transported to Ben Taub General Hospital, Houston, Texas,after received a gunshot wound in the lower back at approximately 10:00 p.m. on September 5, 1998. The decedent received emergency surgery but resuscitative efforts failed. Death was pronounced on September 6, 1998, at 12:46 a.m.

AUTOPSY: The autopsy was performed in the Joseph A. Jachimczyk Forensic Center of Harris County by Chief Medical Examiner Joye M. Carter, M.D., pursuant to Article 49.25, Texas Code of Criminal Procedure, beginning at 9:00 a.m., on September 6, 1998.

CLOTHING: The decedent was received nude.

Upon close inspection of the body, there was a stud earring in the left earlobe, which was yellow metal and a clear small stone.

EVIDENCE OF MEDICAL INTERVENTION: The body was received with the following: bilateral stapled venous cut-down incisions on the medial surface of both ankles; nasogastric tube inserted in the right naris which was not taped; an endotracheal tube was inserted orally and was secure; bilateral chest tube insertions with drainage; 10 inch, left thoracotomy incision; 13 inch, midline laparotomy incision; vascular accesses through the right subclavian and right wrist; a 4 inch, coarsely sutured, left inguinal incision; a Foley catheter in situ; and hospital identification around the right great toe.

EXTERNAL APPEARANCE: The body received was that of a young black male whose facial appearance was consistent with the recorded age of 27 years. The body was warm to the touch and rigor mortis was not yet fully formed. There was unfixed lividity on the posterior surface. The body had a length of 74 inches and a weight of 238 pounds. The head was normocephalic and atraumatic, covered by closely cropped, dark brown, kinky hair, which measured less than 1/4 inch in length. Facial hair consisted of a trimmed moustache and goatee with existing beard stubble. There were no palpable skull or facial bone fractures. The irides were brown with pupillary diameter of 4 millimeters, bilaterally. The conjunctivae were clear and free of petechial hemorrhages. The nares were intact and contained dried excrement. Dentition was natural and in fair condition. The buccal mucosa was unremarkable. There was a stub earring in the left earlobe. The right and left external auditory canals contained no unusual fluid. There was a single pierced hole of the left earlobe and none of the right. The neck was midlined and the organs were unremarkable. There was no ligature or furrow marks on the anterior neck. There was some asymmetry to the chest due to the thoracotomy incision. The

nipples were mildly protuberant, without palpable masses. The abdomen was mildly protuberant. Of note was the midline, coarsely sutured, laparotomy incision. The external genitalia were those of an adult male. The penis had been circumcised. Both testicles were palpated within the scrotal sac. There was no apparent gross injury to the scrotum. The upper extremities were symmetrical and well formed. Both arms were remarkable for venipuncture wounds in the antecubital fossae, secondary to medical therapy. There were no tattoos, venous track marks, or unusual scars of the upper extremities. The lower extremities were symmetrical and well formed and remarkable for the aforementioned medical therapy to the medial surfaces of the ankles. Both hands displayed short fingernails. The toenails were untrimmed but unremarkable. The posterior surface was remarkable for unfixed lividity and a penetrating gunshot wound to the midline of the buttocks.

INTERNAL EXAMINATION: Section: The thoracoabdominal area was explored through the Y-shaped incision. Upon reflecting the skin and soft tissue, chest tube insertion was noted on the left side, beneath the 7th rib and on the right side beneath the 6th rib. There was a red rubber drain exuding from the left thoracotomy incision with drainage. With exception of the chest tube insertion and thoracotomy, the rib cage was intact with no fractures observed. The sternum was intact. The midline fat at the level of the umbilicus was 2-1/4 inches in depth. The pericardial sac had been surgically entered. The heart had undergone cardiac massage, manually. There was a drain inserted into the right atrium. The right and left pleural cavities each contained approximately 100 cubic centimeters of recent blood. The peritoneal cavity contained thirteen, blood-soaked gauze pads.

HEART: The heart was remarkable for a red rubber drain inserted into the right atrium and stitched in place. Upon removal of the drain, the heart had a residual weight of 475 grams. The heart was of normal configuration and firm consistency. The epicardial surface was remarkable for diffuse areas of petechial hemorrhages on the anterior surface. There was moderate subepicardial fatty tissue deposition. The fatty tissue was yellow in color. The coronary arteries arose normally in the aortic root and were thin-walled with no evidence of narrowing due to atherosclerosis. The coronary arteries followed a normal course through the epicardial surface. The myocardium was firm, red-brown and homogenous throughout. All heart valves were thin and delicate. The tricuspid valve had a 12 centimeter circumference, the pulmonic valve had a 7 centimeter circumference, the mitral valve had a 10 centimeter circumference, and the aortic valve had a 6 centimeter circumference. The endocardial surface was focally hemorrhagic, secondary to manual massage. There were no septal defects noted. The entire aorta was dissected. There was a defect in the left iliac artery and vein, which had been isolated and attempts at surgical repair were made. There were no other injuries noted to the vascular system.

LUNGS: The right and left lungs weighed 550 grams and 400 grams, respectively. The pleural aspects were pink-tan-gray and glistening. There was minimal anthracotic pigment noted. Upon sectioning, the pulmonary arterial tree was free of thromboemboli. Upon sectioning the bronchial system, the right bronchi were patent with a smooth pink-tan mucosal surface. The secondary right bronchi were filled with thick, tenacious, tan mucous plugs. Upon sectioning the bronchi of the left lung, large globs of thick, tan mucous plugs were observed in all large and secondary airways. Upon sectioning, the pulmonary parenchyma was markedly congested and edematous. There were no palpable areas of consolidation. Sectioning showed three areas of mucous plugs in the smaller airways. There was minimal anthracotic pigment deposition noted on the cut surfaces.

LIVER: The liver was intact with a weight of 2100 grams. The capsular surface was red-brown and glistening. The inferior margin was sharp. Serial sectioning of the hepatic parenchyma revealed it to be red-brown and homogenous in appearance. There was no evidence of space-occupying lesions. The gallbladder bed was intact and contained approximately 20 cubic centimeters of thin, yellow-green bile. The bile passages were patent. There was no evidence of cholelithiasis. The gallbladder mucosa was velvety green in appearance.

PANCREAS: The pancreas was intact with a weight of 175 grams. There was moderate increase of peripancreatic fatty tissue. Upon sectioning, the parenchyma was pink-tan and normally lobulated. The duct was widely patent. There were no areas of fibrosis noted.

SPLEEN: The spleen was intact with a weight of 100 grams. The capsular surface was purple-brown and wrinkled. The hilum was intact. Upon sectioning, the parenchyma was homogenous and red-brown in appearance. Moderate lymphadenopathy was noted in the cervical region.

ADRENALS: The right and left adrenal glands were unremarkable upon sectioning, displaying yellow cortices and gray-brown medullary regions.

GENITOURINARY TRACT: Each kidney weighed 175 grams. The renal capsules stripped with ease revealing lobulated, smooth, red-brown cortical surfaces. There was no evidence of cysts or scarring. Upon sectioning, there was normal depth to the cortices, bilaterally. The medullary regions were mildly congested. The collecting systems were unremarkable. Both ureters followed a normal course to the bladder. The urinary bladder was void of urine due to the presence of an indwelling Foley catheter. The subserosal tissue of the bladder was markedly hemorrhagic due to the gunshot wound pathway. The bladder mucosa was pale tan and normally trabeculated. The prostate gland measured 1-1/4 by 1-1/4 inches. Upon sectioning, there was no evidence of increased nodularity. The right and left testes were intact. The left

testis was remarkable for serosal hematoma due to its relationship to the gunshot wound pathway. The testes themselves had not been violated and were normal in appearance. The pelvis was remarkable for a graze defect on the left lateral wall. This defect was secondary to the gunshot wound pathway.

GASTROINTESTINAL TRACT: The esophagus was intact and free of injury. Its lining mucosa was gray-white and smooth. The esophageal gastric junction was intact, without laceration. The gastric contents were approximately 150 cubic centimeters of well masticated, chocolate brown liquid. There was no tablet or pill residue within the gastric contents. Upon rinsing, the gastric mucosa displayed erythematous change from mucosal petechiae. There was no evidence of ulceration. The pyloric channel was patent. The first part of the duodenum was free of ulceration. There was a small amount of tan chyme within the first section of the duodenum. The remainder of the small intestine was unremarkable and free of injury. The appendix was in its normal anatomic location. The large intestine was remarkable for one perforating lesion of the sigmoid colon and marked mesenteric hematoma formation in the vicinity of the gunshot wound to the left side of the pelvis.

NECK ORGANS: The right sternocleidomastoid muscle was remarkable for hematoma and laceration secondary to insertion of vascular access in the subclavian area on the right side of the upper chest. The left subclavian region was intact and unremarkable. The remainder of the strap muscles were unremarkable. The tongue was firm and intact, without evidence of injury. The thyroid gland was bilobed, red-brown, and firm and homogenous upon sectioning. The hyoid bone, thyroid and cricoid cartilages were intact. The epiglottis was not swollen. The glottis was normal in appearance. The pharynx was not obstructed. The larynx was opened posteriorly. The laryngeal mucosa was pale tan and covered by a thin film of gastric contents. The vocal folds were normal in appearance. The tracheal rings were not collapsed. There was some erythema noted to the mucosal surface of the trachea. The underlying cervical spine was intact, without evidence of fracture.

HEAD: The scalp was reflected via a bimastoidal incision. There was no galeal or subgaleal hematoma. The temporalis muscles were bilaterally intact. The calvarium was intact and free of fracture. The dura mater was intact, without epidural or subdural hematoma formation. The leptomeninges covering the brain were translucent. The brain had a weight of 1300 grams. The vessels forming the circle of Willis were thin-walled and delicate with no evidence of malformation. Upon sectioning the brainstem, cerebellum, and cerebral hemispheres, there was no evidence of preexisting lesion or intracerebral hematoma. The pituitary gland was in its normal anatomic location. The basilar was intact and free of fracture line.

DESCRIPTION OF INJURY: One penetrating gunshot wound was observed of the body.

The gunshot wound occurred on the posterior surface of the body at the formation of the buttocks, at 35-1/2 inches below the top of the head, 25-1/2 inches below the top of the shoulder, and exactly in the midline. The defect was circular, measuring 1/4 inch in diameter, with a narrow abrasional ring. To the left of the defect was an abrasion which measured 3/4 inch by 1/4 inch. To the right of the defect was a small abrasion, measuring 7/16 inch. There was a ring of contusion surrounding the abrasion on the right buttock, which measured approximately 5 by 2 inches. The wound pathway penetrated the skin, subcutaneous tissue, and deep muscular tissue of the buttock. The wound pathway traveled back to front, fractured the sacrum, then slightly right to left, and entered the pelvic cavity where it grazes the left aspect of the pelvis, continuing to travel forward where it perforated the left iliac artery and vein, traveling forward penetrated the deep musculature of the abdominal pelvic wall, where the projectile embedded within and was located 23-1/2 inches below the top of the shoulder, left of the abdominal midline. A deformed, copper-jacketed projectile was recovered from within the deep muscular tissue of the abdominal pelvic wall. The wound pathway was back to front, right to left, and slightly upward. The wound pathway was associated with extensive blood loss due to perforation of the iliac vessels. The entrance wound was not associated with muzzle imprint or gunpowder tattooing.

TOXICOLOGY: Samples of blood, bile, vitreous, gastric contents, and liver were retained for toxicological analysis.

HISTOLOGY: Representative sections of all major organs were retained in formalin.

PATHOLOGICAL FINDINGS

1. Penetrating gunshot wound to lower back.
2. Perforation of left iliac artery and vein.
3. Status post surgical intervention with repair to the left iliac vessels and advanced cardiac life support.

OFFICE OF THE MEDICAL EXAMINER OF HARRIS COUNTY
JOSEPH A. JACHIMCZYK FORENSIC CENTER
1885 OLD SPANISH TRAIL
HOUSTON, TEXAS 77054-2098

REPORT OF ANALYSIS

September 16, 1998

TO: Joye M. Carter, M.D.
Chief Medical Examiner

CASE#: ML98-2463

Evidence submitted on 09/08/98.

RESULTS:

Blood: Ethanol, Methanol, Acetone, Isopropanol- Not Detected.
Phencyclidine- Less than 0.1 mg/L
Marihuana Metabolite, Cocaine Metabolite, Opiate,
Amphetamine/Methamphetamine- Not Detected.

Unless otherwise requested, specimens will be discarded one year after date of receipt.

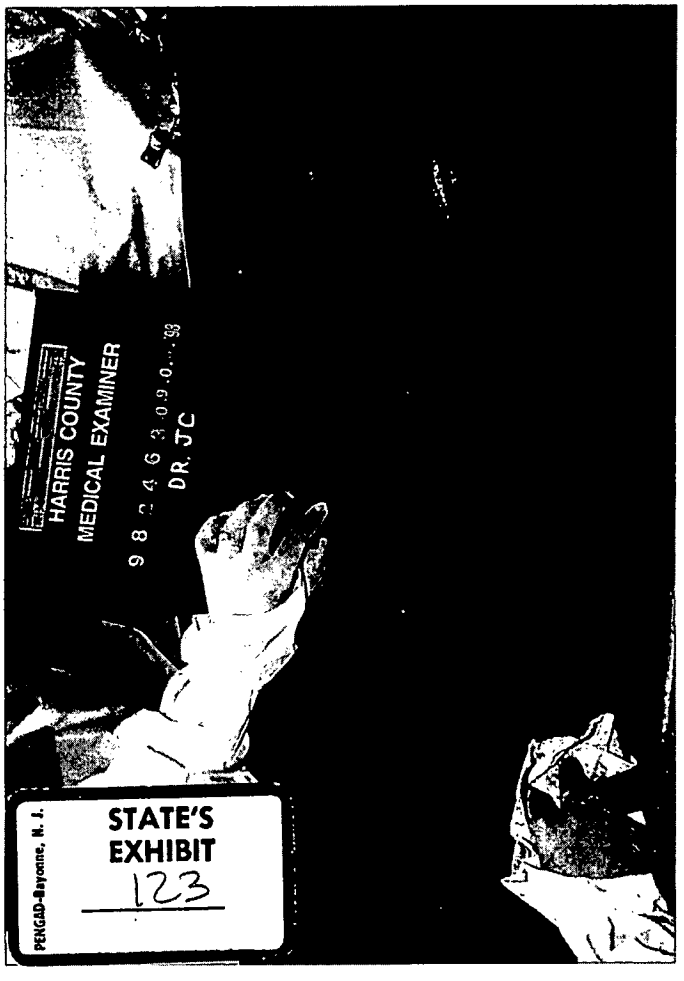
Patricia L. Small, B.S., MT, ASCP
Assistant Toxicologist

Ashraf Mozayani, Ph.D., DABFT
Chief Toxicologist

RECEIVED
SEP 22 1998
MEDICAL EXAMINER

Medical Examiner's Initial

STATE'S EXHIBIT NO. 123


HARRIS COUNTY
MEDICAL EXAMINER
DR. JC
STATE'S
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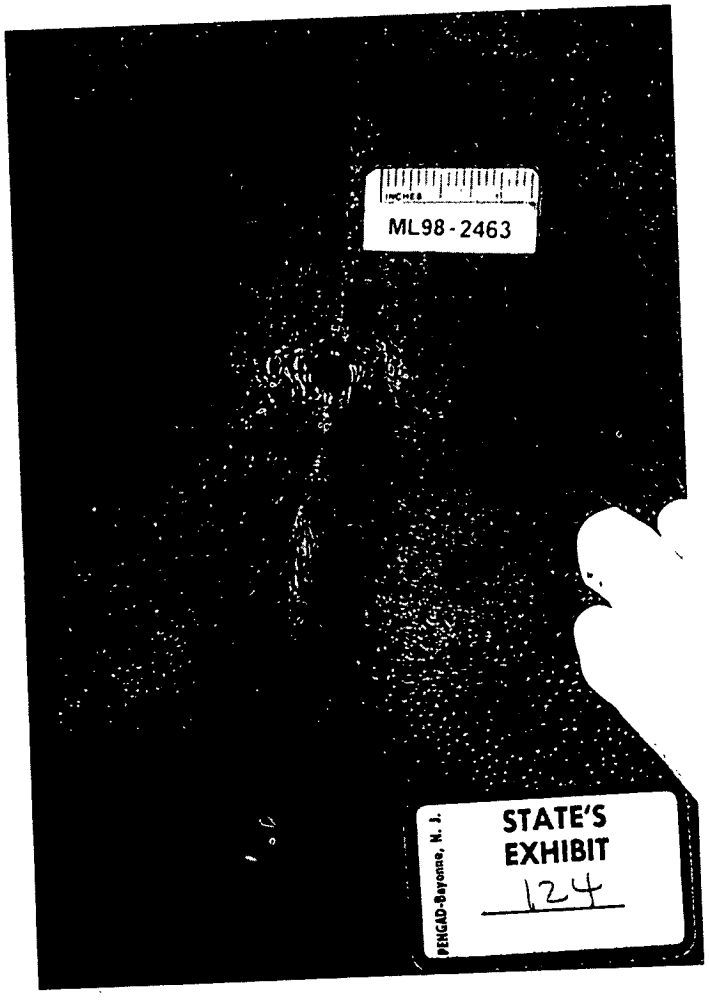
123
PENGAD-Bayonne, N. J.

STATE'S EXHIBIT NO. 124


ML98-2463
STATE'S
EXHIBIT
124
PENGAD-Bayonne, N. J.

STATE'S EXHIBIT NO. 125

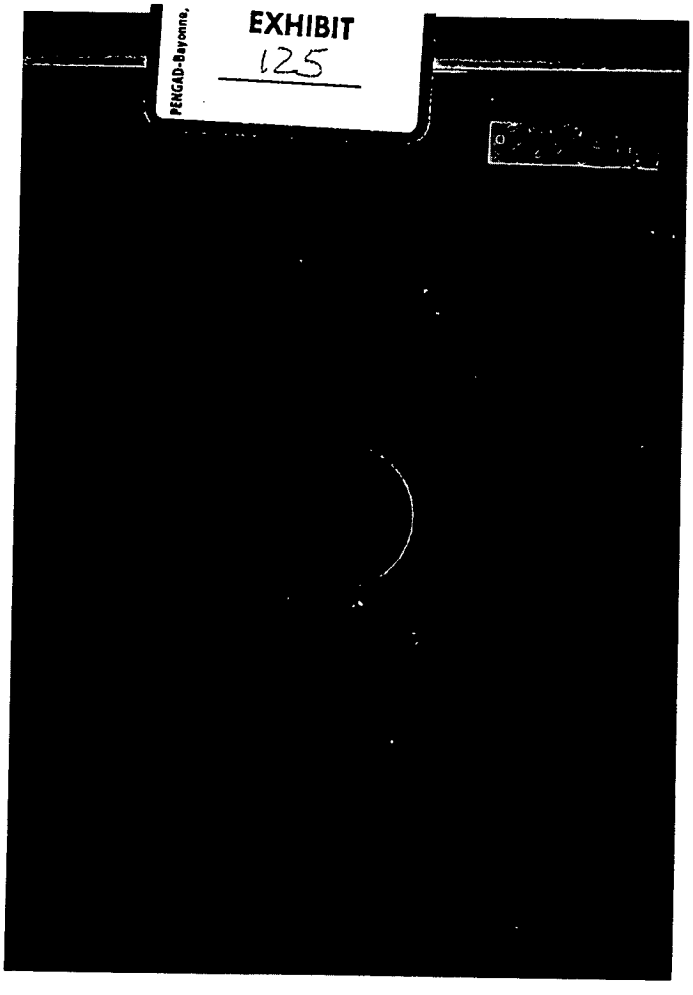


EXHIBIT
125
PENGAD-Bayonne,

STATE'S EXHIBIT NO. 126

BODY CHART

PHYSICAL EVIDENCE

STATE'S EXHIBIT NO. 127

AFFIDAVIT

Before me, the undersigned authority, personally appeared RENEE SORENSEN, who being by me duly sworn, deposed as follows:

My name is Renee Sorensen and I am of sound mind, capable of making this affidavit, and am personally acquainted with the facts herein stated:

I am the custodian of the records of HERMANN HOSPITAL, 6411 FANNIN, HOUSTON, TEXAS 77030

Attached here are 308 pages of records from the medical records of:

Kevin Walter AKA Kane Wilford
(Name of Patient)

Hospital Stay Period: 12-7-98 - 12-31-98
(Admission and Discharge Date)

These said pages of records are kept by said Hospital in the regular course of business, and it was the regular course of business of said Hospital for an employee or representative of said Hospital, with knowledge of the act, event, condition, opinion or diagnosis recorded, to make the record was made at or near the time or reasonably soon thereafter. The record attached hereto is the original or exact duplicate of the original and no other documents exit on the files for the above named person, which pertain to the admission and discharge, noted above.

Renee Sorensen
(Signature)

SWORD TO AND SUBSCRIBED before me on this 6TH day of Oct, 1999.

STATE'S EXHIBIT 127

Faye Long
Notary Public in and for the STATE OF TEXAS

FAYE LONG
Notary Public
STATE OF TEXAS
My Commission Expires 04-28-2002

FAYE LONG
(Printed Name)

My Commission Expires: 4-28-2002

HERMANN HOSPITAL

Patient Registration

0100

PATIENT DEMOGRAPHIC INFO

Patient Type	Privacy Code	Religion	Pre Admit By	Admit By	Print By
INPAT		NON		ECCFL	NADMC 12/07/98 05:09

Date Admitted	Time	M.R./Account Number	Patient Location	Accom. Data	Service	Financial Class	PC
12/07/98	01:07	969254909367	STIC09	W	TRM	NON-RESOURCE	

Discharge Date	Age	Date of Birth	Sex	MS	Social Security No.	Race	Admit Type	Admit Source	Acc. Code
12-31	24	05/04/1974	M	S	999-49-5490	B	EMERG	ER	6

Patient's Name: WALTER ,KEVIN VIP:

Patient's Address (1): 7321 WHIPPRECHT ST

Patient's Address (2):

City, State, Zip: HOUSTON TX 77026

Country/County: HAR Phone: 713-633-7919

Patient's Employer: NOT EMPLOYED

Employer's Address (1):

Employer's Address (2):

City, State, Zip:

Employer's Phone: - - 0 Ext.: LOE: 0

Occupation: NOT EMPLOYED

Patient's Spouse:

Father's Name:

Mother's Name:

Mother's Account Number:

EMERGENCY

Name: WALTER-DOMINO ,TWANETTE Relation: M

Employer's Name:

Home Phone: 713-633-7919

Work Phone: - - 0

COMPLAINT

879.9 OPN WOUND SITE NOS-COMP

Proc: ELOS: 0

GUARANTOR INFORMATION

Guarantor's Name: WALTER ,KEVIN

CPI #: 96925490 DOB: 05/04/74

Address (1): 7321 WHIPPRECHT ST

Address (2):

City, State, Zip: HOUSTON TX 77026

Home Phone: 713-633-7919 Relation: P

Social Security No.: 999-49-5490

Guarantor's Employer: NOT EMPLOYED

Address (1):

Address (2):

City, State, Zip:

Work Phone: - - 0 Ext.:

Occupation: NOT EMPLOYED

Effective Date: 01/01/01

MEDICAL

Admitting Physician: DUKE, JAMES H. (TRAUMA) UPIN B87573
Fax: 713-797-2963 DR# 04965

Attending Physician: DUKE, JAMES H. (TRAUMA) UPIN B87573
Fax: 713-797-2963 DR# 04965

PCP Physician: NO FAMILY PHYSICIAN UPIN
Fax: DR# NONE

IPA/PHO:

Referring Physician: NO REFERRING PHYSICIAN UPIN
Address: DR# NONE

City, State, Zip:

Transfering Institution:

Last Hospital Activity Date

I/P Clinic Site:

O/P Life Flight #: MOA: F

E/R Discount Type:

PRIMARY INSURANCE

Insurance Co.: Code:

Insured:

S.S.# or Certificate#: D.O.I. (If w. Comp.):

Group#: Eff. Date: Contr:

Verified With: Date:

Phone: Ext.:

AOB: N Authorization:

Medicare B: Blueshield:

Mail Claim to:

Rvw Agcy: Ph.:

SECONDARY INSURANCE

Insurance Co.: Code:

Insured:

S.S.# or Certificate#:

Group#: Eff. Date: / /

Verified With: Date:

Phone: Ext.:

AOB: Authorization:

Medicare B: Blueshield:

Mail Claim to:

Rvw Agcy: Ph.:

Comments: MOTHER ENROUTE/NO LD INS/AOB DEMO

Info By: MOTHER

FP	ASM	ANAL	CD	Diagnosis Codes	Procedure Codes

cc: #JAMES H. DUKE, M.D., FAX # 5007268
cc: HARVINDERPAL SINGH, M.D.

HERMANN HOSPITAL

NAME OF PATIENT: WALTER, KEVIN
UNIT #: 9692549
SSN#:
DOB:
ROOM NUMBER:
DATE OF ADMISSION: 12/07/98
DATE OF DISCHARGE: 12/31/98
ATTENDING PHYSICIAN: #JAMES H. DUKE M.D.

ADMITTING DIAGNOSIS:
1. Multiple gunshots wounds to the chest and abdomen.
2. Right hemopneumothorax.
3. Intrahepatic abscesses.

PROCEDURES PERFORMED:
1. Exploratory laparotomy.
2. Ligation of hepatic artery.
3. Cholecystectomy.
4. Right chest tube, feeding tube and hepatic drain placement via interventional radiology.

HISTORY OF PRESENT ILLNESS: The patient is a 24-year-old man with multiple gunshot wounds who was noted to have a hemopneumothorax on the right, one gunshot wound over the right chest near the nipple line, left shoulder, left thigh and abdomen. A right chest tube was placed. The patient was emergently taken to the operating theater and underwent exploratory laparotomy with ligation of common hepatic artery and cholecystectomy. The patient had a massive arterial hemorrhage from his common hepatic artery. Please see the patient's hospital chart for further details on the patient's hospital stay and hospital summary. The patient was subsequently taken to the shock-trauma intensive care unit. The patient had NJ tube placed and was started on enteral nutrition. Postoperatively, the patient began to spike fevers. CT of the abdomen revealed a necrotic area of the liver. The patient was started on intravenous antibiotics. Blood cultures revealed Gram negative rods. The patient also had an E. coli urinary tract infection on 12/15/98. On 12/15/98, the patient had drains placed by interventional radiology in the subdiaphragmatic area. The patient was weaned off the ventilator and right-sided chest tube was subsequently discontinued without any complication after control of chest tube drainage and there was air leak. The patient's abdominal wound was packed at the time of the original surgery. The patient had daily dressing changes.

On 11/21/98 the patient had another evacuation of a fluid collection in the liver under ultrasound guidance. Simultaneously, the patient was seen by physical therapy to increase his ambulation, strength training and range of motion. The patient completed a course of antibiotics. Repeat CT scan done on 12/26/98 revealed decreased fluid in the right liver lobe compared to before. Following this, the patient had an uneventful hospital stay. The patient's antibiotics were discontinued. The patient had low-grade fevers which were contributed to atelectasis. The patient was discharged home.

DISCHARGE MEDICATIONS: Colace 100 mg b.i.d.; Vicodin one to two p.o. q.4-6h. p.r.n.

FOLLOW UP CARE: The patient is to follow up with Dr. Duke in the outpatient surgery clinic. The patient is to receive home health for daily dressing changes as well as drain maintenance. The patient's tube feeds were discontinued. The patient was tolerating a regular diet at the time of discharge.

DICTATED BY:

HARVINDERPAL SINGH M.D.
RESIDENT

REVIEWED BY:

#JAMES H. DUKE M.D.
ATTENDING PHYSICIAN

/131 J: 3788 CL:
D: 12/31/98 T: 12/31/98

Disclosure and Consent
Medical and Surgical Procedures

HERMANN HOSPITAL
DISC & CON MEDI & SUR PROC
96 92549 0 9367
WALTER , KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

4003

Patient Name
Last
First
Middle

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure

I (we) voluntarily request that Dr. Duke & Assoc, as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, treat my condition which has been explained to me as: Gunshot wound to chest & abdomen, back & left shoulder.

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: Exploratory laparotomy with possible thoracotomy as well as any other indicated procedures.

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) ☐ do ☐ do not consent to the use of blood and blood products as deemed necessary. K W

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I (we) also realize that the following risks and hazards may occur in connection with the particular procedure: Death, Infection, Bleeding, Paralysis, Damage to viscera & /or blood vessels.

(See Following Pages)

I (We) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (We) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (We) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (We) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache or chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

I (we) authorize my physician and the hospital to dispose of, in accordance with accustomed practice, any tissues or body parts surgically removed.

DATE 12/7/98 TIME 10:00 am

Kevin Walter
Signature of Patient or Other Legally Responsible Person

Signature of Witness

6411 Fannin
Witness Address

Houston, Texas 77030-1501
Witness City, State, Zip Code

Consent could not be obtained in person. I explained by telephone all necessary information and obtained informed consent. The conversation was witnessed by the person whose signature appears above.

Signature of Physician

RISKS AND HAZARDS

The following are the risks and hazards associated with treatments and procedures established by the Texas Medical Disclosure Panel. Full disclosure of these risks and hazards is required by the physician or health care provider to the patient or person authorized to consent for the patient.

(i) The Texas Medical Disclosure Panel has not established a risk disclosure standard for the proposed procedure(s). My physician has discussed with me the risks of the procedure(s) such that I am able to give my informed consent.

PT. INITIALS

(ii) Blood transfusions:

☐ (1) fever
(2) transfusion reaction, which may include kidney failure and/or anemia
(3) heart failure
(4) hepatitis
(5) AIDS
(6) other infections

PT. INITIALS

1. Anesthesia.

☐ (A) Epidural.
(1) Risks are enumerated in the informed consent form.
(B) General.
(1) Risks are enumerated in the informed consent form.
(C) Spinal.
(1) Risks are enumerated in the informed consent form.

PT. INITIALS

2. Digestive system treatments and procedures.

☐ (A) Cholecystectomy with or without common bile duct exploration.
(1) Pancreatitis.
(2) Injury to the tube between the liver and the bowel.
(3) Retained stones in the tube between the liver and the bowel.
(4) Narrowing or obstruction of the tube between the liver and the bowel.
(5) Injury to the bowel and/or intestinal obstruction.

PT. INITIALS

3. Ear treatments and procedures.

☐ (A) Stapedectomy.
(1) Diminished or bad taste.
(2) Total or partial loss of hearing in the operated ear.
(3) Brief or long-standing dizziness.
(4) Eardrum hole requiring more surgery.
(5) Ringing in the ear.

PT. INITIALS

☐ (B) Reconstruction of auricle of ear for congenital deformity or trauma.
(1) Less satisfactory appearance compared to possible alternative artificial ear.
(2) Exposure of implanted material.

PT. INITIALS

☐ (C) Tympanoplasty with mastoidectomy.
(1) Facial nerve paralysis.
(2) Altered or loss of taste.
(3) Recurrence of original disease process.
(4) Total loss of hearing in operated ear.
(5) Dizziness.
(6) Ringing in the ear.

PT. INITIALS

4. Endocrine system treatments and procedures.

☐ (A) Thyroidectomy.
(1) Injury to nerves resulting in hoarseness or impairment of speech.
(2) Injury to parathyroid glands resulting in low blood calcium levels that require extensive medication to avoid serious degenerative conditions, such as cataracts, brittle bones, muscle weakness and muscle irritability.
(3) Lifelong requirement of thyroid medication.

PT. INITIALS

5. Eye treatments and procedures.

☐ (A) Eye muscle surgery.
(1) Additional treatment and/or surgery.
(2) Double vision.
(3) Partial or total loss of vision.

PT. INITIALS

☐ (B) Surgery for cataract with or without implantation of intraocular lens.
(1) Complications requiring additional treatment and/or surgery.
(2) Need for glasses or contact lenses.
(3) Complications requiring the removal of implanted lens.
(4) Partial or total loss of vision.

PT. INITIALS

☐ (C) Retinal or vitreous surgery.
(1) Complications requiring additional treatment and/or surgery.
(2) Recurrence or spread of disease.
(3) Partial or total loss of vision.

PT. INITIALS

☐ (D) Reconstructive and/or plastic surgical procedures of the eye and eye region, such as blepharoplasty, tumor, fracture, lacrimal surgery, foreign body, abscess, or trauma.
(1) Worsening or unsatisfactory appearance.
(2) Creation of additional problems such as:
a. Poor healing or skin loss.
b. Nerve damage.
c. Painful or unattractive scarring.
d. Impairment of regional organs, such as eye or lip function.
(3) Recurrence of the original condition.

PT. INITIALS

☐ (E) Photocoagulation and/or cryotherapy.
(1) Complications requiring additional treatment and/or surgery.
(2) Pain.
(3) Partial or total loss of vision.

PT. INITIALS

☐ (F) Corneal surgery, such as corneal transplant, refractive surgery and pterygium.
(1) Complications requiring additional treatment and/or surgery.
(2) Possible pain.
(3) Need for glasses or contact lenses.
(4) Partial or total loss of vision.

PT. INITIALS

☐ (G) Glaucoma surgery by any method.
(1) Complications requiring additional treatment and/or surgery.
(2) Worsening of the glaucoma.
(3) Pain.
(4) Partial or total loss of vision.

PT. INITIALS

Disclosure and Consent
Medical and Surgical Procedures

HERMANN HOSPITAL
DISC & CON MEDI &-SUR PROC

4003

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Patient Name _____
Last _____
First _____
Middle _____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure

I (we) voluntarily request that Dr. Wallace, Cohen, Middlebrook, as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, treat my condition which has been explained to me as: Intrahepatic lesions

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: Hepatic drain

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) ☐ do ☐ do not consent to the use of blood and blood products as deemed necessary.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I (we) also realize that the following risks and hazards may occur in connection with the particular procedure: Bleeding, Infection, Damage to liver

(See Following Pages)

I (We) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (We) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (We) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (We) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache or chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

I (we) authorize my physician and the hospital to dispose of, in accordance with accustomed practice, any tissues or body parts surgically removed.

DATE 12/21/98 TIME 0730 X Kevin Walter
Signature of Patient or Other Legally Responsible Person

RENEE' JARVIS, RN
Signature of Witness

6411 Fannin
Witness Address

Houston, Texas 77030-1501
Witness City, State, Zip Code

Consent could not be obtained in person. I explained by telephone all necessary information and obtained informed consent. The conversation was witnessed by the person whose signature appears above.

_____
Signature of Physician

Disclosure and Consent
Medical and Surgical Procedures

HERMANN HOSPITAL
DISC & CON MEDI & SUR PROC

4003

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Patient Name _____
Last _____
First _____
Middle _____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure

I (we) voluntarily request that Dr. _____, as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, treat my condition which has been explained to me as: _____

need for enteral access

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: _____

naso jejunal tube placement

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) ☐ do ☐ do not consent to the use of blood and blood products as deemed necessary.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I (we) also realize that the following risks and hazards may occur in connection with the particular procedure: _____

intestinal perforation, need for another procedure

(See Following Pages)

I (We) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (We) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (We) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (We) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache or chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

I (we) authorize my physician and the hospital to dispose of, in accordance with accustomed practice, any tissues or body parts surgically removed.

DATE 12/16/98 TIME 1015

X Kevin Walter
Signature of Patient or Other Legally Responsible Person

Robert Ivan RN
Signature of Witness

6411 Fannin
Witness Address

Houston, Texas 77030-1501
Witness City, State, Zip Code

Consent could not be obtained in person. I explained by telephone all necessary information and obtained informed consent. The conversation was witnessed by the person whose signature appears above.

_____
Signature of Physician

Disclosure and Consent
Medical and Surgical Procedures

HERMANN HOSPITAL
DISC & CON MEDI & SUR PROC

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

4003

Patient Name
Last
First
Middle

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure

I (we) voluntarily request that Dr. Cohen/Middlebrook, as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, treat my condition which has been explained to me as:

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: Abdominal drain, liver fluid collection aspiration

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) ☐ do ☐ do not consent to the use of blood and blood products as deemed necessary.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I (we) also realize that the following risks and hazards may occur in connection with the particular procedure: infection, damage to liver, damage or collapse of lung, pain.

(See Following Pages)

I (We) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (We) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (We) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (We) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache or chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

Phone Consent

I (we) authorize my physician and the hospital to dispose of, in accordance with accustomed practice, any tissues or body parts surgically removed.

DATE 12/15/98 TIME 1630

Signature of Patient or Other Legally Responsible Person

Signature of Witness

6411 Fannin
Witness Address

Houston, Texas 77030-1501
Witness City, State, Zip Code

Consent could not be obtained in person. I explained by telephone all necessary information and obtained informed consent. The conversation was witnessed by the person whose signature appears above.

Signature of Physician

1

HERMANN HOSPITAL
EMERGENCY CENTER RECORD
PRESS HARD YOU ARE MAKING 4 COPIES

9929549O-9367
WALTER ,KEVIN
B M 24 Y 05/04/1974

UNABLE TO OBTAIN
EDMXR 12/07/98 00:23

AGE 1

20:22 DATE: 12/07/98 TRIAGE NURSE: GREMILLION RN, J.
IE: E
VAL CODE: MODE OF INJURY NONE/NOT KNOWN E928.9

TIENT'S HOME PHONE: - - 0 WORK PHONE: - - 0

URGENCY CODE ☐ I ☐ II ☐ IIB

ME:	TEMP:	PULSE:	RESP:	BP:
N ROOM	TET / /	LMP	WT. 0 LBS	POLICE NOTIFIED 0 EZ

PREVIOUS EC VISIT	EC SERVICE N

TIME	PHYSICIAN / PREFERRED CODE	TIME(S) NOTIFIED	TIME(S) RESPONDED / ARRIVED	COMMENTS
	UNABLE TO OBTAIN			

PRE-ARRIVAL INFORMATION	CURRENT MEDICATIONS:	ALLERGIES:

CC: AIN
HPI:

See Trauma H+P

PM Hx:
F Hx:
SOC Hx:
ROS:

T:	P:	R:	BP: /	GENERAL APPEARANCE:

PE:

PA/PG 1 . 2 SIGNATURE & ID	PG 3 / 4 / 5 SIGNATURE & ID	ATTENDING SIGNATURE & ID

2

ERMANN HOSPITAL
MERGENCY CENTER RECORD
AGE 2

PRESS HARD YOU ARE MAKING 4 COPIES

96925490-9367
WALTER ,KEVIN
B M 24 Y 05/04/1974

UNABLE TO OBTAIN

DATE 12/07/98

TIME	DIAGNOSTIC INTERVENTIONS:	RESULTS/INTERPRETATIONS

TREATMENT INTERVENTIONS:

OBSERVATIONS/CLINICAL COURSE SUMMARY:

ATTENDING PHYSICIAN'S COMMENTS: c staff pt seen & examined c 4 - GSW Dr Duke present Alert ASS entrance (R) chest ↓BS LUQ c entrance paralumbar abd (R) ... (R) hemothx GSW c/ back CT (R) then OR for lap

CLINICAL IMPRESSION(S): 1. Multi GSW 2. (R) hemothx 3.

DISCHARGE INSTRUCTIONS

OR

DISCHARGE MED. (DOSE/SIG/QTY.)

DISPOSITION OF PATIENT

☐ SOCIAL WORKER NOTIFIED ☐ HOME ☒ INPATIENT ☐ OBSERVATION ☐ PATIENT TRANSFERRED ☐ DECEASED

FOLLOW UP DATE & TIME	BED CONTROL NOTIFIED	REASON FOR TRANSFER	NEXT OF KIN NOTIFIED
FOLLOW UP SITE	BED ASSIGNED	ACCEPTING FACILITY	PASTORAL CARE NOTIFIED
INSTRUCTION SHEET COMPLETED & UNDERSTOOD ☐ YES ☐ NO	REPORT GIVEN TO ICU / ROOM	ACCEPTING PHYSICIAN	MEDICAL EXAMINER NOTIFIED
PATIENT CLASSIFICATION (CIRCLE ONE) 1 2 3 4 5 (6)	ADMIT ATTENDING M.D. Duke	MODE OF TRANSFER	BODY RELEASED TO
CONDITION OF DISCHARGE Critical	ADMIT SERVICE Trauma	COPY OF CHART, X-RAYS, & RESULTS:	FAMILY PHYSICIAN NOTIFIED
PATIENT'S SIGNATURE	DISCHARGE OF VALUABLES	DISPOSITION OF VALUABLES	DISPOSITION OF VALUABLES
DISCHARGE ... SIGNATURE & ID	PA/PG 1 2 SIGNATURE & ID	PG 3, 4, 5 SIGNATURE & ID	ATTENDING'S SIGNATURE & ID #

V1505

MEDICAL RECORDS

HERMANN HOSPITAL EMERGENCY CENTER

TRAUMA RESUSCITATION FLOW SHEET

96 92549 0 9367
WALTER , KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

PATIENT INFORMATION

DATE: 12-6-98 DOB: 5-4-74
TIME: 2320 AGE: 24 (M) F
PATIENT NAME:
ID # :

CODE: I II III
VIA: ☐ LIFE FLIGHT ☐ H.F.D. (#) ☐ AUTOMOBILE
☐ AMBULANCE (#) ☐ OTHER

MODE: ☐ STRETCHER ☐ CARRY ☐ WHEELCHAIR ☐ WALK

MECHANISM OF INJURY

- ☐ MOTORCYCLE
- ☐ BICYCLE
  - ☐ HELMET
  - ☐ PROTECTIVE CLOTHING
- ☐ AUTO/PEDESTRIAN
- ☐ AUTO
  - ☐ SEATBELT
  - ☐ AIRBAG
  - ☐ CARSEAT
- ☐ DRIVER
- ☐ PASSENGER
  - ☐ FRONT ☐ BACK
- ☐ DEATH OF OTHER OCCUPANT(S)
- ☐ IMPACT TO:
  - ☐ FRONT ☐ REAR
  - ☐ RIGHT ☐ LEFT
  - ☐ ROLLOVER
- ☐ IMPACT WITH:
- ☐ ESTIM. M.P.H.
- ☐ LOC X MIN.
- ☐ EJECTION X FEET
- ☐ PROLONGED EXTRICATION X MIN
- ☐ AMPUTATION
- ☐ BLUNT/ASSAULT
- ☐ BURN
- ☐ CHOKE/ASPIRATION
- ☐ CRUSH/TISSUE LOSS
- ☐ DIVING
- ☐ FALL FEET
- ☒ GSW/SGW X 4
- ☐ INHALATION
- ☐ NEAR DROWNING
- ☐ OVERDOSE
- ☐ STAB/IMPALEMENT
- ☐
- ☐

PRIOR TO ARRIVAL (PTA)

- ☐ AIRWAY:
  - ☐ ORAL ☐ NASAL
  - ☐ INTUBATED
  - ☐ CRICOTHYROTOMY
  - ☐ O_2 ☐ MASK ☐ CANULLA
- ☐ BACKBOARD IMMOB.
- ☐ CERVICAL COLLAR
- ☐ CHEST TUBE: ☐ RT ☐ LT
- ☐ NEEDLE THORACOTOMY
- ☐ IV (s) X
- ☐ FOLEY
- ☐ MAST PANTS
  - ☐ HYPOTENSION
  - ☐ IMMOBILIZATION
- ☐ SPLINT
- ☐ GCS 15
- ☐ VITAL SIGNS:
  - ☐ BP
  - P
  - R
  - T
- ☐ RHYTHM:
- ☐ MANNITOL
- ☐
- ☐
- ☐
- ☐

TRAUMA

TITLE	TRAUMA ATTENDING	CHIEF TRAUMA RESIDENT	TRAUMA RESIDENT	EC RESIDENT	
NAME					
NOTIFIED AT	PTA	PTA	PTA		
ARRIVED AT					

NURSING

RN RECORDER	
NURSE	
NURSE	
ECT	

CONSULTS

TITLE	ANESTHESIA	PLASTIC	ORTHOPEDIC	NEURO						
NAME										
NOTIFIED AT										
ARRIVED AT										

OTHER

OTHER	RESPIRATORY	X-RAY	CT	SOC. WORK	PASTORAL	FAMILY	ICU/PICU				
NOTIFIED AT	PTA	PTA	PTA								
ARRIVED AT											

INITIAL ASSESSMENT

CHIEF COMPLAINT: SP GSW X4

PAST MEDICAL HISTORY: UNK

☐ SMOKER ☐ ETOH ABUSE ☐ DRUG ABUSE

BP 130/76
P
R
T
LMP
Preg ☐ X wks
Wt.
Tetanus UNK

ALLERGIES: UNK

MEDICATIONS: UNK

AIRWAY

- ☐ PATENT
- ☐ STRIDOR
- ☐ OBSTRUCTED
- ☐ AIRWAY (ORAL / NASAL)
- ☐ ETT # FR
- ☐ TRACH
- ☐ CRICO

BREATHING

RESPIRATIONS
- ☐ REG @ MIN.
- ☐ IRREG @ MIN.
- ☐ ABSENT
- ☐ SPONTANEOUS
- ☐ LABORED
- ☐ SYMMETRICAL
- ☐ ASYMMETRICAL

- ☐ FLAIL SEGMENT
- ☐ RETRACTIONS
- ☐ SUBCUTANEOUS EMPHYSEMA
- ☐ SUCKING CHEST WOUND
- ☐ TRACHEAL DEVIATION

ASSISTED VIA
- ☐ SUCTIONING
- ☐ O_2 ☐ MASK ☐ CANNULA @ L/MIN.
- ☐ HUMIDIFIED
- ☐ AMBU-BAG
- ☐ VENTILATOR

R	L	LUNG SOUNDS	VENTILATOR SETTINGS
		CLEAR	FIO_2
		DIMINISHED	TIDAL VOL.
✓		ABSENT	RATE
		CRACKLES/RALES	PEEP
		WHEEZES/RHONCHI	

CIRCULATION

PALPATED PULSE:
- ☐ REGULAR
- ☐ IRREGULAR
- ☐ ABSENT

EXTERNAL BLEEDING:
- ☐ NO
- ☐ YES
- ☐ CONTROLLED WITH

MONITORED:
- ☐ NORMAL SINUS
- ☐ SINUS TACHYCARDIA
- ☐ OTHER
- ☐ CPR IN PROGRESS
- ☐ SEE CPR RECORD

CAPILLARY REFILL:
- ☐ < 2 SEC. (NORMAL)
- ☐ > 2 SEC. (DELAYED)

COMMENTS:

IMMOBILIZATION

- ☐ CERVICAL COLLAR BY
- ☐ FULL SPINAL IMMOBILIZATION BY
- ☐ RESTRAINTS TO:

HEAD

RIGHT PUPIL 3 mm
- ☐ REACT ☐ FIXED
- ☐ CONSTRICTED
- ☐ DILATED

LEFT PUPIL 3 mm
- ☐ REACT ☐ FIXED
- ☐ CONSTRICTED
- ☐ DILATED

DRAINAGE:
- ☐ NONE
- ☐ NOSE (COLOR)
- ☐ EARS (COLOR)
  - ☐ RIGHT ☐ LEFT
- ☐ CSF
- ☐ HALO SIGN
- ☐ GLUCOSE (+ / −)
- ☐ BATTLE SIGNS
- ☐ RACCOON EYES

FONTANELLES:
- ☐ N/A
- ☐ FLAT
- ☐ DEPRESSED
- ☐ BULGING

COMMENTS:

☐ SEE ANATOMICAL DIAGRAM

96 92549 0 9367
WALTER , KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

LABORATORY, RADIOLOGIC & OTHER STUDIES

TEST	DRAWN/DONE	COMMENTS	
☑ Betadine prep for labs	K. Lewis EMT-P	FA OA	
Trauma I	Panel III sent		
Trauma II			
DIC			
T & Cross # 6/2			
C-Spine	✓	Done	
CXR	✓		
Pelvis			
EKG			
Cysto/RUG			
IVP			
Extremity: R / L			
____ ☐R ☐L			
____ ☐R ☐L			
____ ☐R ☐L			
____ ☐R ☐L			
T-Spine			
L-Spine			
Skull			

TEST	ORDER TIME	TIME TO	TIME BACK	ACCOMPANIED BY
CT ☐C-Spine ☐Brain ☐Abd ☐ ____				
Angio				

MEDICATION / DOSE	ROUTE	SITE	TIME / BY	COMMENTS
DT 0.5cc	IM	R. Delt	0835	Lot # 478514 Expires: 3/99 Manu: WYETH ☐No Adverse Reactions
				☐No Adverse Reactions
				☐No Adverse Reactions
				☐No Adverse Reactions
				☐No Adverse Reactions
				☐No Adverse Reactions

TIME	BP	P	R	T	GCS / RTS E	V	M	PUPILS R	L	PULSE OX	$[E_tCO_2]$
0840	106/71	118	24		3	5	6	3	3	100	
0845	89/40	115	24		3	5	6	3	3	100	
0850	96/63	120	22		3	5	6	3	3	100	

TIME	FLOWSHEET / NURSES' NOTES
0830	rec'd to trauma
	via EMS s/p multi
	GSW to both + chest
	+ ABD. A+A Ox3
	on BB c̄ C-Collar intact Dp
0900	To OR via
	Stretcher Dp

☐DISCHARGE TO ____ @ ____
INSTRUCTIONS GIVEN RE: ____
☐ENGLISH ☐SPANISH
☐INTERPRETED BY: ____

☐ADMITTED TO STICU @ ____
REPORT CALLED TO ____ Dp

☐AMA
☐LEFT WITHOUT BEING SEEN

OR

☐DEATH PRONOUNCED @ ____
TRANSFERRED TO: ____ @ ____
☐LIFE GIFT NOTIFIED
☐ORGAN DONOR
☐AUTOPSY TO BE DONE

MODE: ☐AMB ☐CARRY ☐WHEELCHAIR ☐STRETCHER

ACCOMPANIED BY: ☐ALS EQUIPMENT ☐MD ____ ☐FAMILY/FRIEND ☐RN ____ ☐OTHER ____

CONDITION: ☐GOOD ☐FAIR ☐SERIOUS ☐CRITICAL

VALUABLES:
☐NONE ☐DISCARDED
☐TO LOCK BOX ☐TO OFFICER
☐WITH PATIENT BADGE # ____
☐TO FAMILY

PREVIOUS PAGES AND ABOVE PER VERBAL ORDER
R.N. D Pendleton INT.
R.N. ____ INT. ____
R.N. ____ INT. ____
M.D. TEAM LEADER ____
M.D. ____

[redacted]

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ____________________

OTHER: ____________________

WT: __________ kg. HT: __________ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/25/98	10 am	(1) Transfer to 5G/6E Team Dr. Duke
		(2) s/p Gunshot wound - Ex Lap / Cholecystectomy / Hepatic Art Ligation / Hepatic Abscess
		(3) Stable
		(4) Reg Diet
	#429	(5) Promote @ 85cc/hr via FT
	#438	(6) PT - Consult ↑ Endurance
		(7) IVFs - D5½NS ē 20meq KCl @ 30cc/h
		(8) MEDs - Sef 440mg IVPB q 8°
		Levofloxacin 500mg IV q 24°
		Vancomycin 2gm IVPB q 8°
		Omeprazole 20mg po q 24°
		Phenergan 12.5-25mg IV q 4° prn n/v
		Vicodin 1-2 po q 4° prn Pain
		MSO4 2mg IV q 3° prn Severe Pain
		Colace 100mg po BID
		Tylenol 650mg po q 4° prn HA or Temp >101
		(9) Flush Suprahepatic Drain ē 5-10cc NS q shift
	#440	(10) Resp. - IS 10X q hr
		wean O_2 to keep Sat ≥92%
	#441	IDB q 6°
	#437	Alb 2.5mg ē 3cc NS q 6° prn
		(11) Call HO for any problem
		Temp >101
		BP >170/90 <90/50
	#439	(12) CXR in Am
		(13) Make sure CT Abd is ordered STAT
		(14) Dressing to abd
		W-D ē NS q Shift
		[signature] for / Dr. Duke 3403
		[signature] 12/25/98 5:45pm

FAXED 12/25 4:05pm

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/25/98	630	① D/C O2, Replace if Sats <94% ② D/C Chest tube ③ Flush both drains ④ CXR portable Upright Pat Bryanton 12/25/98 7A Warren 22268
12/25/98	715	Chest Check — Pat Bryanton

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HERMANN HOSPITAL

Physician's Orders

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ALLERGIES: ☐ NKA ☐ YES

DRUG: ______

OTHER: ______

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WT: ______ kg. HT: ______ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/24/98	0918	(1) Regular Diet
		(2) CT scan of Abdomen / Pelvis #421 #425
		(3) Change tube feeds to Promote at 85cc/h #424
		(4) CXR #426 #420 done
		2. Noye
		Bridget 1130 Pat Bryant 12/24/98
12/24		NPO after midnite for …
		Ella Mae McDonald 12-24-98 4:20
12/25/98	0245	24° chart check Geralda Alvarez

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ______

OTHER: ______

WT: ______ kg. HT: ______ cm.

ORDERED DATE	ORDERED TIME	**ORDERS** **Use Ball Point - Press Firmly**
12/23	1000	Dulcolax Supp PRN QD
		docusate Na 100mg DHT Q12°
		v.o. Dr Summer / Stephen Rn
		B Bates 12/23/98 [signature]
12/23/98 1400		1) Flush suprahepatic drain c̄ 5-10cc saline q shift.
		Dale R Abshen MD
		Ottie Edwards RN @ 1529 12/23/98 404-3679
		B Bates RN 12/23/98 1800.
12/23/98 1845		12° Chart ✓ B Bates RN
12/24/98 0220		24° Chart Check [signature]
12/24/98 730P		Chart Check — Pat Bryant RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

MEDICAL RECORDS

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☑ NKA ☐ YES gIMU-6

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/23/98	925	Transfer to SIMU - Dr. Duke
		Dx: SIP GSW to abdomen, exploratory laparotomy, ligation common hepatic artery and resolving hepatic abscess c multiple drains
		Cond - stable
		Vitals - per routine
		Activity - OOB to chair TID
		Nursing - ~~Foley~~ D/C Foley, Record drain outputs #393
		Diet - #402 Clear, advance as tolerated & Impact @ 110cc/hr
		IVF - NS TKO (20cc/hr)
		Meds - ① Gentamicin 440mg IVPB q 8°
		② Levofloxacin 500mg IVPB q 24°
		③ Vancomycin 2.0gm IVPB q 8°
		④ Omeprazole 20mg susp po q 24°
		⑤ chlorpromazine 25mg IM q 6° prn
		⑥ vicodin 1-11 tabs po q 3° prn pain
		⑦ Ibuprofen 200mg po q 6° prn X
		⑧ MSO4 2mg IV q 3° prn severe pain not alleviated by vicodin X
		⑨ Promethazine 25mg IV q 6° prn N/V
		⑩ Tylenol 650mg PO/PR q 6° prn HA or temp > 101.5
		Respiratory Consult #405
		IDB q 4° #406
		Incentive spirometry 10-15 breaths/waking hr #409
		2L Nasal cannula to keep O2 sats > 94% #408
		call MD if temp > 101.5, SBP > 170 < 90, DBP > 110 < 50, U.O < 0.5cc/kg/hr
		Chem 7, CBC c PID in AM.
		Notify M.D. for SMU upon arrival.
		Atrin nasal spray + saline nasal spray prn congestion

Kathy Edwards 12/23/98 @ 1526

Emergency 23120

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

ANTIBIOTIC/PHYSICIAN REORDERS

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words-MEDICAL NECESSITY"

ALLERGIES: ☐ YES ☐ NO

DESCRIBE:

HERMANN HOSPITAL

Antibiotic/Physician Reorders

Patient Name : WILFORD, KANE **
Medical Record # : 96925490
Location : STIC STIC-19

Print Date : 12/23/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point-Press Firmly

THE ORDERS BELOW ARE SCHEDULED TO EXPIRE WITHIN 48 HOURS UNLESS RENEWED. PLEASE INDICATE WHETHER THE FOLLOWING SHOULD BE CONTINUED BEYOND THE INDICATED STOP DATE OR DISCONTINUED BY CHECKING THE APPROPRIATE LINE BELOW.

DRUG	DOSE	ROUTE	FREQ	START	STOP	CONTINUE	DC	ORDER #
HYDROCODONE W/APAP 5MG/5	1TAB	PO	Q3HPRN	12/11/98	12/25/98	✓	-------	422239
LEVOFLOXACIN 500MG/D5W 1		IV	Q24	12/18/98	12/25/98	✓	-------	447630
BASE SOLUTION	100ML							
LEVOFLOXACIN 500MG/100	500MG							

Summer
NAME (PRINTED)

SIGNATURE

12/23
DATE

TIME

BEEPER #

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

LABORATORY

CBC — WBC: ___ Hgb: 6 Hct: 36.3 Plts: ___

PT: ___ PTT: ___

ABG — FiO2: ___ Ph: ___ PCO2: ___ PO2: ___ HCO3: ___ Sat: ___ BE: ___ Vent: Yes / No

SMA 7 — Na: ___ K+: ___ CO2: ___ Cl: ___ BUN: ___ Cr: ___ Gluc: ___

LFT — Amylase: ___ Alk Phos: ___ LDH: ___ Bili: ___ SGOT: ___ SGPT: ___

UA — SpGr: ___ Ph: ___ Chem: ___ Micro: ___ RBC: ___ WBC: ___ Bact: ___ Gravidex: + -

EKG: Normal Abnormal

HERMANN HOSPITAL

Trauma Adm Rec

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

DPL — GROSS + - RBC ___ WBC ___ Amylase ___ Alk Phos ___ GM Stain ___ Other ___

TOX — URINE BLOOD ETOH ___ MARIJUANA COCAINE OTHER SALICYLATES

RADIOLOGY

	Obtained	PENDING	RESULTS	REMARKS
CT	☐ HEAD	☐		
	☐ C-SPINE	☐		
	☐ ABDOMEN	☐		
	☐ CHEST	☐		
CXR	☒ SUPINE	☐	HTX / PTX Bullet Lt Shoulder	
	☐ MEDIASTINAL	☐		
X-RAY Spine	☐ C-SPINE	☐		
	☐ T-SPINE	☐		
	☐ L-SPINE	☐		
	☐ PELVIS	☐		
Extremity	☐ ___ R L	☐		
	☐ ___ R L	☐	Abdomen No FB	
	☐ ___ R L	☐		
	☐ ___ R L	☐		
	☐ ___ R L	☐		
	☐ ___ R L	☐		
	☐ ___ R L	☐		
Other	☐ ___	☐		
	☐	☐		
	☐ ULTRASOUND	☐		

Admitting Resident: 24 y/o B ♂ GSW in abdomen GCS 15 BP 118 4 [illegible] wounds Good [illegible] all [illegible]

Signature: [illegible] MD

DIAGNOSIS

SYSTEM	POSITIVE FINDINGS	CONSULTS	FOLLOW UP
NEURO	GCS #15		
RESP	Rt Hemopneumothorax - C.T. GSW		
CARDIAC	Tachycardia		
GI	Obese - GSW		
GU			
ORTHO	No Deformity		
EXTERNAL	Multiple GSW		

Attending Staff: 24 Y/O — Multiple GSW to Chest and Abdomen. Gross morbid obesity. Transported by HFD - GCS #15; BP 118/P; P 120. ~7 min. On arrival GCS #15. BP 106/71. P. [illegible] PX [illegible] & Pts Bevere [illegible] - GCS #15. Multiple GSW chest/abd. CXR. Rt Hemothorax. Chest tube placed 800 mL rapidly drained, given PRBC — Crossmatched/type specific. Palp bullet Lt shoulder GSW Rt chest, back, abd. to OR. Expl. Lap. [illegible]

Signature: [illegible]

TRAUMA ADMIT RECORD

HERMANN HOSPITAL
Trauma Adm Rec

House Officer: Reyes/Jurnick
Attending: Duke
Time Seen:

HPI

Age 24 (M) F RACE: Caucasion (Black) Hispanic Native American Asian

MVC: Driver Passenger SPEED: High Moderate Low RESTRAINTS: None Belt Air Bag Both
MECHANISM: Windshield Steering Wheel Intrusion Death of occupant Ejection Extrication

MCA: Driver Passenger SPEED: High Moderate Low RESTRAINTS: None Helmet
Autoped: SPEED: High Moderate Low
Fall: DISTANCE:
Crush: LOCATION:
Assault: OBJECT:
(GSW:) (Stab:) LOCATION: Head Neck (Thorax) (Abdomen) Extremity Extremity Back

x2 x1

PMH

MI Htn Angina CHF Stroke Anisocoria DM Seizure Asthma COPD None
Kidney DZ HIV+ Hepatitis Other: Last Tetanus: LMP: Preg: Y N
ALLERGY: NKDA PCN Sulpha Cephalasporin Codeine Other NKDA

SURG

Describe: CSX

MED

Name	Dose	Frequency	Name	Dose	Frequency
ASA					
Coumadin					
None					

ETC

ETOH Marijuana Cocaine Ø
Barb Heroin Other:
Tobacco: Ø PPD
Last Meal: 1100 pm

VS

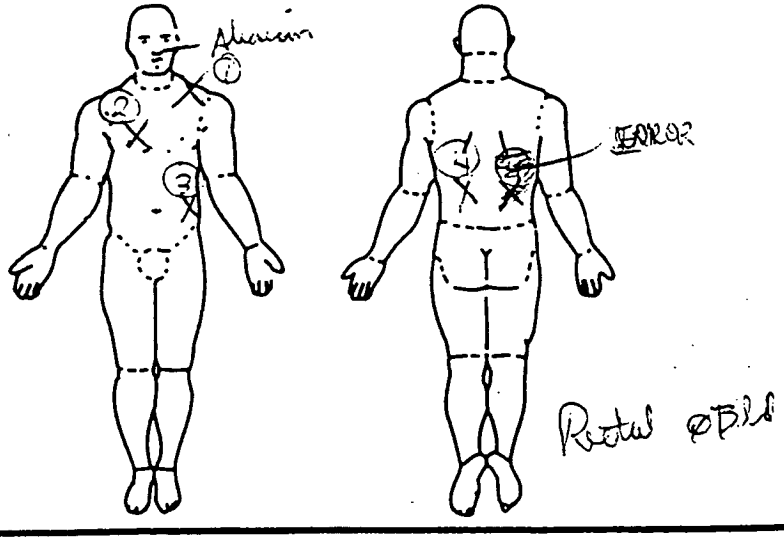
FIELD: BP 118 P 120 RR T GCS 15
EC: BP 130/76 P 114 RR 20 T GCS 15

TRANSPORT ISSUES: Scoop and Run

PHYSICAL EXAM

HEAD		WNL	(ABNL)	
EYES		WNL	ABNL	
TMS	R	WNL	ABNL	
	L	WNL	ABNL	
NECK		WNL	ABNL	
CHEST	R	WNL	(ABNL)	Needle Wound
	L	WNL	ABNL	
ABD		WNL	(ABNL)	LUQ
PELVIS		WNL	ABNL	
GENITAL		WNL	ABNL	
BACK		WNL	(ABNL)	Rt Lumbar
EXTREMITY	R	WNL	ABNL	
	L	WNL	ABNL	
NEURO		WNL	ABNL	15 ECS

DESCRIBE



Hermann Hospital

Day of Discharge Orders

Kevin Walter

1010

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Admitting Date: 12-7-98
Admitting Dx.: Gbw & RLL
Discharge Date: 12-29-98
Discharge Dx.: Hemolytic Anemia
Liver Disease
Colitis
Referring M.D.:

Procedures / Treatment Performed / Date

Pertinent Test Results

Discharge Medication	Dose	Times per Day	Drug Class
Colace	100 mg	2x BID	
Ciprofloxacin	1-2 tabs	q 6° prn	

Comments/Final Progress Notes (For Stays ≤ 48 Hrs)

Came to ER for fever >101, increased abdominal pain

___ Patient Provided with Medication Information Sheet/Sheets

Discharge Diet If Appropriate: Regular Diet

___ Describe diet instruction provided:

Signature of R.D. (if applicable)

Follow-Up Care:

	Physician	Date	Office Number	Fax Number
1	Dr Duke	704 6025	in 1 week call for appt	
2				
3				

Home Care Agency: Office #: Fax #:

Referred for:

Special Instructions: No heavy lifting or over exertion Activity as tolerated

When to call the doctor - Call at: (Phone) for: (Danger Signals)

Resumption of Normal Activities: Date you can return to work: 1/4/16 Date you can resume driving a car: 3 wks

Date you can resume your normal sexual activities: 3 wks with no heavy lifting

___ Patient Education Materials provided:

By signing this form, I acknowledge receipt of the above information.

Patient/Family Member Signature: Kevin Walter Phone Where You Can Be Reached:

Signatures: M.D. M.D.-Beeper #: Discharging R.N. M. Jayaraman

Unit Secretary: FAX TO 1 Attending Physician
2 Follow-Up Physician(s)
3 Home Health Central Intake (40022) if Home Health Ordered Above.

Form 431612 (3/96)

White Copy-Hospital Medical Records

Yellow Copy-Patient

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☐ NKA ☐ YES JSB

DRUG: ______

OTHER: ______

WT: ______ kg. HT: ______ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED		ORDERS Use Ball Point - Press Firmly
DATE	TIME	
		D/C [illegible]
		D/C feeding tube
		[signature] 12/31/98 [signature] 24784
		10:20 A Lesley [illegible] FAXED
12/31/98		[illegible] already ordered
		Home health [illegible] drain BID
		[illegible] output, [illegible]
		[signature] 12/31/98 [signature] 24784 4:48p
		D/C 1.0
		D/C [illegible] [signature] 24784
		[signature] 12/31/98 4:54 pm

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ______

OTHER: ______

WT: ______ kg. HT: ______ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/28/98	1805	12° chart check. Kim Lawrence, RN
12/29/98	0100	CC —— Rita Rawell, RN
12/29/98	1140	(1) DC All IV Antibiotics Please — [signature] PA / [signature] 24610
		[signature] VS 12/29/98 13:56pm
		12-29-98 1820 12°CC R. Henderson RN
12/29/98		RT chart ✓ LeRoy Lowe RCP
12/30		24° CC ✓ [illegible]
12/30/98	1800	12° Chart ✓ Lesley Sears RN
12/30/98		RT chart ✓ LeRoy Lowe RCP
12/31/98	2400	CC —— Rita Rawell, RN

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431641 (6/95)

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ______

OTHER: ______

WT: ______ kg. HT: ______ cm.

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ORDERED DATE	TIME	ORDERS — Use Ball Point - Press Firmly
12/27/98		DC chart ✓ [signature]
12/27/98		PT chart [signature]
12/28/98	0315	150 cc - m. Tampa... [illegible]
12/28/98		D/C Tube feeds [signature] Singh 24784
		HCLU
		Vicodin I-II po q4° prn
		D/C PCA
		PT to ambulate TID
12/28/98		(1) Home Health ORDER
		W→D c NS + Kerlix to Abd Wound Care c Abd + secure c Montgomery Straps ...
		Change BID
		Teach family to do care
		FAXED
		(2) Drain in liver - flush drain c 10cc NS tid + record output
12-28-98	9:21	Feeding tube clamped - not using presently
		[signature] 54010
		Plan D/C Home 12/29/98

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

MEDICAL RECORDS

1/- ... RN 12/28/98 1445

HERMANN HOSPITAL

Physician's Orders

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ______________________

OTHER: ______________________

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

WT: __________ kg. HT: __________ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/26		24° [illegible]
12/26/98		TF [illegible] at 35 [illegible]
		[signature] 12/26/98 [signature] 24784
		11 28/[illegible] [signature]
12/26/98	1900	12° Chart ✓ [signature]
12/27/98	0330	12° Chart ✓ [signature]
12/27/98		~~CBC~~, SMA-7, LFT (452, 454)
		CBC ē diff 453 [signature] 24784
12/27/98 (0755)		Chest PT please ē Agressive Pulm toilet
		[signature] MD 23019 — PT notified 2207
		[signature] 12/27/98 930/[illegible] [signature]

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

MEDICAL RECORDS

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ______________________

OTHER: ______________________

WT: __________ kg. HT: __________ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/21/98	2200	12° RT Chart ✓ [illegible] RN
12-22-98	0700	12° Chart ✓ P. Felton, RN / RJARVIS, RN
12/22/98	0945	✓ Chem 7 at 1300 [illegible]
		✓ Culture bilirubin [illegible] x1 [illegible] 2310
		RENEE' JARVIS, RN
12-22-98	1000	↑ TF TO 110cc/°
		V.O. DR. SUMNER / RENEE' JARVIS, RN
		RENEE' JARVIS, RN
12/22/98		RT Chart Check - [illegible] rec
12-22-98	1900	12° CHART CHECK RJARVIS, RN / P. Felton, RN
	2230	12° chart ✓ P. Felton, RN / [illegible]
12/23/98		RT Chart Ch [illegible]
12/23	0950	Afrin & NS nasal spray PRN
		VO Dr Nguyen [illegible] [illegible]

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

MEDICAL RECORDS

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	ORDERS — Use Ball Point - Press Firmly
12/4/98 0840	VO ✓ chem 7 ~~this~~ IN am RENEE' JARVIS, RN
12/12/98 0840	JOB Q4° & PRN NC to keep Sat 94% VO Dr. Talabi RENEE' JARVIS, RN
12/21/98 0945	1) CXR p Line placement. RENEE' JARVIS, RN
12/21/98 1130	Ang. c orders Vessel Inj IV Fentanyl 50 mcg IV Percutaneous liver Drain to gravity RENEE' JARVIS, RN
12/31/98 12:35	1) D IVF to TKO RENEE' JARVIS, RN
12-21-98 1900	12° CHART CHECK RENEE' JARVIS, RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

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ess otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ORDERED DATE	ORDERED TIME	**ORDERS** — **Use Ball Point - Press Firmly**
12/20/98	1610	1) INTERVENTIONAL RADIOLOGY: ORDERS PERCUTANEOUS DRAINAGE INTRAHEPATIC BILOMA (SEE WIDAS SCAN) DUKE 521-1200
12-20-98	2020	RT 12° chart ✓ / S.Tol ECP
12/20	2300	4° chart ✓ m / P. Tillotson
12/21	01	Pt needs have Benadryl 50mg IV X1 for sleep P. Tillotson RN V.O. Dr Zaafran/Pcm
12/21/98	0630	D/c daily Icu panels Chem-7 q d when O2 to keep Sat >92% - D/c if possible P. Tillotson, RN
12-21-98	0700	12° chart ✓ P. Tillotson, RN / RJARVIS, RN 19 / 124 (Bradley

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

"Authorization is hereby given to dispense the Generic or Chemical equivalent ess otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ORDERED DATE	TIME	**ORDERS** Use Ball Point - Press Firmly
12/20/98	0700	Make total fluids = 125cc/hr V.O. D. Simon DR ALLEN
12/20/98	08:50	1) C. Diff, Stool Ca, fecal lactoferrin done 12-20-98 2) Lomotil x 1 ✓ 3) Keep NPO ✓ Zantac 23168
12/20		D/C NGT ✓ Adv to Clear liquid diet ADI
12/20/98	1315	NPO p midnight V.O. D. Berger DR ALLEN
12/20/98	1900	12° Chart ✓ DR ALLEN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

ANTIBIOTIC/PHYSICIAN REORDERS

Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words-**MEDICAL NECESSITY"**

ALLERGIES: ☐ YES ☐ NO

DESCRIBE:

HERMANN HOSPITAL

Antibiotic/Physician Reorders

Patient Name : WILFORD, KANE **
Medical Record # : 96925490
Location : STIC STIC-19

Print Date : 12/19/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point-Press Firmly

THE ORDERS BELOW ARE SCHEDULED TO EXPIRE WITHIN 48 HOURS UNLESS RENEWED. PLEASE INDICATE WHETHER THE FOLLOWING SHOULD BE CONTINUED BEYOND THE INDICATED STOP DATE OR DISCONTINUED BY CHECKING THE APPROPRIATE LINE BELOW.

DRUG	DOSE	ROUTE	FREQ	START	STOP	CONTINUE	DC	ORDER #
LORAZEPAM	2MG	IV	Q2-4HPRN	12/12/98	12/21/98	✓		422846
MORPHINE	2MG	IV	Q2-4HPRN	12/14/98	12/21/98	✓		429029
GENTAMICIN 440MG/NS 100M		IV	Q8H	12/16/98	12/23/98	✓		436085
NACL 0.9%	100ML							
GENTAMICIN	440MG							

Sumner
NAME (PRINTED)

SIGNATURE

12/20
DATE

0430
TIME

23285
BEEPER #

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☑ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367

WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
		Pharmacy Clarification
12/18/98	1616 pm	Vancomycin 2gm IV Q8H take through after 3rd dose V/O PR. Sumner Wayne A. Evers RPh
		noted — [illegible] MD
12/19	0700	12° chart ✓ m
12/19/98	0630	due [illegible] sent + CT + drain for bilirubin due + HIDA scan - evaluate for leak [illegible] MD Summers 23285
12/19/98	0735	12° RT chart Check - Stuckman
12/19/98	1850	12° Chart Check [illegible]
12-19-98	2035	RT 12° chart ✓ S. Rolen RCP
12/20/98		12° Chart ✓ [illegible] RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

"Authorization is hereby given to dispense the Generic or Chemical equivalent
ess otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	TIME	**ORDERS** Use Ball Point - Press Firmly
12/8/98	10:15	1) ATF to Impact @ same rate (goal of 110 cc/hr)
		Hermann 13
12/18/98		2) D/c Cefepime / Ampicillin
1500		Levaquin 500 mg IV q d - std by Pharmacy pager 24281 for any questions
		3) Vancomycin 1 gm IV q 12°
		Hermann 23335
12/18 1900		12° cc

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	TIME	ORDERS — Use Ball Point - Press Firmly
12/17	98 1756	Ampicillin 2g Q6hrly I.V Kclark 23156
12/17/98		12° cc infection — J. Scott RN
12/19	SK 0140	V.O. DR. KOWALSKI: IPV Q4-6 c PS Shiba, CRT, Reg
12/18		12° chart J. Scott RN Early
12/18/98		12° Rt Chart check - Stickers

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

ANTIBIOTIC/PHYSICIAN REORDERS

...uthorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words-**MEDICAL NECESSITY"**

ALLERGIES: ☐ YES ☐ NO

DESCRIBE:

HERMANN HOSPITAL

Antibiotic/Physician Reorders

Patient Name : WILFORD, KANE **
Medical Record # : 96925490
Location : STIC STIC-19

Print Date : 12/18/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point-Press Firmly

THE ORDERS BELOW ARE SCHEDULED TO EXPIRE WITHIN 48 HOURS UNLESS RENEWED. PLEASE INDICATE WHETHER THE FOLLOWING SHOULD BE CONTINUED BEYOND THE INDICATED STOP DATE OR DISCONTINUED BY CHECKING THE APPROPRIATE LINE BELOW.

DRUG	DOSE	ROUTE	FREQ	START	STOP	CONTINUE	DC	ORDER #
HYDROCODONE W/APAP 5MG/5	1TAB	PO	Q3HPRN	12/11/98	12/19/98	-------	X	422239
TEMAZEPAM	15MG	PO	PRN	12/12/98	12/19/98	✓	-------	423065

NAME (PRINTED)

SIGNATURE

12/18 DATE

0830 TIME

23285 BEEPER #

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431934

Date & Time	Date of Service NURSING SUMMARY : 7A-7P
12-22-98	NEURO ANXIOUS @ TIMES & C/O PAIN IN RUQ WHICH WAS RELIEVED BY MSO4 & ATIVAN RESP 2L NC, SpO2 ≥ 94-97%, RR ↓ 28-32 CV REMAINS TO BE TACHY 120's GI TF ↑ TO 110 PER ORDER & TOLERATING, ØBM, HEPATIC DRAINS INTACT @ 200 OUT OF INTRA GU ADEQUATE OUT INTEG ABD. WOUND GRANULATING WELL, GSW's @ NO DRNG OR SIGNS OF INFECTION. PSYCH FAMILY @ BS FOR SHORT TIME & 2's ANSWERED. R. JARVIS, RN
12-23	Nursing Summary 7P-7A No Dcs from initial assessment Dr My

430016 (Back Page)

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ORDERED DATE	TIME	**ORDERS** Use Ball Point - Press Firmly
12/16/98	1644	Omeprazole 2omg p.o Q.d via NG tube only D/C Sucralfate.
		start Promote @ 15cc/hr 2316
		Robert Evans RN
12/16/98	1900	12° chart ✓ G. Scott RN / Robert Evans RN
12/17/98	0700	12° chart ✓ G. Scott RN /
12/17/98	0002	Wean to CPAP as directed. Rest on SIMV at 4 from 12midnight to 6:00am 12/18 CPAP & Machine + ABG on AM at 12/18 2316
12/19/98		12 hour urine for UUN q SAT 1730 → Sun 0538 Serum prealbumin q Sunday V.O. F Moore MD by M'Dupp RD 2212
12/17/98	1500	Advance TF per protocol NO residuals

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	TIME	**ORDERS** — **Use Ball Point - Press Firmly**
12/16/98		NPO p MN for NJT 12/17 done or call for procedure - demerol 50 mg IV vered 4 mg IV vecuronium 50 mg IV Robert Quinn RN WOOD 24798
12/17/98		for procedure - demerol 100 mg IV done vered 4 mg IV vecuronium 100 mg IV OK to use NJ tube flush NJT c 20 cc WATER TID routine NJT care Robert Quinn RN WOOD 24798
12/16/98 10:00		DC MgSO4 4 mg IV over 40 XT order + see new electrolyte protocol order V.O. Dr Summer / Robert Quinn RN Robert Quinn RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

HERMANN HOSPITAL

Physician's Orders

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ____________________

OTHER: ____________________

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

WT: ________ kg. HT: ________ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12.15.98	2030	RT 12- chart ✓ / S. Tolive RCP
12/16/98	0650	① ~~[illegible]~~ D/C @ 6° 1/1/4
		② Mg SO4 4mg IV over 4° x 1 ✓
		[signature], MD
		noted Robert [illegible] RN [signature] 23285
12/16/98		✓ mechanisms done
		[signature], MD
		noted Robert [illegible] RN [signature] 23285
12/16/98	10:00	1) Gentamicin 440mg q 8° ✓
		2) Draw Gentamicin peak / Trough on 3rd dose ✓
		3) Send drain / CT Drainage for bilirubin done
		C. [signature] Hurtado 23288
		noted Robert [illegible] RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words-MEDICAL NECESSITY"

ALLERGIES: ☐ YES ☐ NO

DESCRIBE:

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point-Press Firmly

Electrolyte Replacement

Disregard all protocols if patient has renal failure, is on dialysis, or has a creatinine clearance <30 ml/min.
Please fill in the electrolyte level and check the appropriate box.
Patients LBW= 100 kg

Magnesium Serum magnesium level: 1.7 mEq/L

Magnesium level 1.0-1.7 mEq/L

☒ Magnesium Sulfate 0.5 mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 3 days.
Recheck magnesium level in 3 days.

Magnesium level < 1.0 mEq/L

☐ Magnesium Sulfate 1mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 1 day, then 0.5 mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 2 days.
Recheck magnesium level in 3 days.

If patient has gastric access and needs a bowel regimen,

☐ Milk of Magnesia (MOM) 15 ml q 24 per gastric tube (NG,OG, PEG). Hold for diarrhea.

Phosphate Serum phosphate level: _____mg/dl

Phosphate level 1.0-2.5 mg/dl:

☐ Tolerating enteral nutrition: Neutra-Phos 2 packets q 6 h per gastric tube or feeding tube.
☐ No enteral nutrition: $KPHO_4$ or $NaPHO_4$ 0.15 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level in 3 days.

Phosphate level < 1.0 mg/dl:

☐ Tolerating enteral nutrition: $KPHO_4$ or $NaPHO_4$ 0.25 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level 4 hours after end of infusion. If <2.5 mg/dl, begin Neutra-Phos 2 packets q6h.
☐ Not tolerating enteral nutrition: KPHO4 OR NaPHO4 0.25 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level 4 hours after end of infusion. If < 2.5 mg/dl, then KPHO4 or NaPHO4 0.15 mMol/kg (LBW) IV over 6 hrs x 1 dose.

Calcium Serum normalized ionized calcium level: _____mg/dl

Normalized calcium level <4.0 mg/dl:

☐ With gastric access (NG, OG, PEG) and tolerating enteral nutrition:
Calcium carbonate susp 1,250 mg/5 ml q6h per NG, OG, or PEG
Recheck ionized calcium level in 3 days.
☐ Without gastric assess or not tolerating enteral nutrition:
Calcium gluconate 2 gm IV over 1 hr x 1 dose.
Recheck ionized calcium level in 3 days.

Potassium Serum potassium level: _____mEq/L

Serum potassium level <4.0 mEq/L:

☐ Asymptomatic, tolerating enteral nutrition: KC1 40 mEq per enteral access x 1 dose.
☐ Asymptomatic, not tolerating enteral nutrition: KC1 20mEq IV q 2h x 2 doses.
☐ Symptomatic: KC1 20 mEq IV q1h x 4 doses.

Recheck potassium level 2 hours after end of infusion. If <3.5mEq/L and asymptomatic, replace as per above protocol.

12/16	0800	[signature]	[signature]	23285
Date	Time	Physician Signature	Physician Name(Print)	Beeper Number

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

435720

Restraint Orders

Critical Care

Authorization is hereby given to dispense the Generic or Chemical Equivalent unless otherwise indicated by the words "MEDICAL NECESSITY."

ALLERGIES: ☐ YES ☐ NO

Describe: _____

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/16/98	0700	**Restraint Orders - Critical Care**
		Patient may be restrained with:
		- Type of restraint:
		☐ Vest ☒ Wrist ☐ Waist ☐ Other:
		- Due to (*state behavior*):
		☒ Pulling at essential tubes or lines ☐ Other:
		- For up to 240 hours (not to exceed 72 hours)
		Restraint
		- May be discontinued when (indicate desired behavior):
		☒ No longer pulling at essential tubes or lines
		☒ Essential tubes or lines are discontinued ☐ Other:
		- Check patient at least Q 1 hour and release at least Q 2 hours for personal care, positioning and skin assessment.
		- Less restrictive interventions tried prior to restraint being initiated:
		☒ Verbal reminders ☐ Family to sit with patient ☐ Other:
		☐ PT and/or ☐ OT consult for suggestions for alternatives to restraints.
		Signature (Physician/Attending): _____ Beeper #: 23285

434276 (10/95)

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/13/98	1410	1) Bolus NS 500cc now. [signature] Herlinda 23281
		(1) Culture of Cath tip done
		(2) ~~U/A~~ Urine culture done
		(3) CXR - portable SH Line Δ. [signature] [signature] Herlinda 23281
12/13/98	1510	Central line ok to use V.O. Dr Summers / [signature] RN
12/14		2-4 mg Ativan > PRN for anxiety 4-8 mg MSO4 V.O. Dr Summers / [signature] RN [signature] RN
12/15/98	1900	12° chart ✓ J. Scott RN / [signature] RN
12/16/98	0700	12° chart ✓ J. Scott RN [signature] RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

MEDICAL RECORDS

HERMANN HOSPITAL

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1014

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ALLERGIES: ☐ NKA ☐ YES

DRUG: ______

OTHER: ______

WT: ______ kg. HT: ______ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/15/98	1115	1) D/C Flagyl 2) Start Gentamycin 600 mg x1 IV 3) Get Gentamycin level 2°, 4°, and 8° p initial dose. [signature] RN T.O. [signature] [illegible] 23281
12/15/98	1123	INTERVENTIONAL RADIOLOGY - HEPATIC ARTERIOGRAM (expedited) Dx: GSW LIVER; C.T. EVIDENCE OF INTRAHEPATIC HEMORRHAGE [signature] RN Duke 521-1200
12/15/98	1130	SIMV 12 V.O. Dr Talabi [illegible] [signature] 23196 [signature] RN
12/15/98	1145	Δ Gent dose to 800 mg IV x 1 [signature] RN [signature] III, MD [signature] 23285
12/15/98	1300	DC Above Hepatic Arteriogram, Send patient to Interventional Radiology for percutaneous drainage of Sipna and intrahepatic collections P.O. Dr Duke / [signature] RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

[signature] RN

431641 (6/95)

MEDICAL RECORDS

straint Orders

Critical Care

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ALLERGIES: ☐ YES ☐ NO

Describe: _____

HERMANN HOSPITAL

Physician's Orders

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WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/15/98		Restraint Orders - Critical Care
		Patient may be restrained with:
		- Type of restraint:
		☐ Vest ☒ Wrist ☐ Waist ☐ Other:
		- Due to (*state behavior*):
		☒ Pulling at essential tubes or lines ☐ Other:
		- For up to 24 hours (not to exceed 72 hours)
		Restraint
		- May be discontinued when (indicate desired behavior):
		☑ No longer pulling at essential tubes or lines
		☑ Essential tubes or lines are discontinued ☐ Other:
		- Check patient at least Q 1 hour and release at least Q 2 hours for personal care, positioning and skin assessment.
		- Less restrictive interventions tried prior to restraint being initiated:
		☑ Verbal reminders ☑ Family to sit with patient ☐ Other:
		☐ PT and/or ☐ OT consult for suggestions for alternatives to restraints.
		Sumner
		Signature (Physician/Attending): _____ MD Beeper #: 6575

434276 (10/95)

HERMANN HOSPITAL

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WILFORD ,KANE **
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ALLERGIES: ☐ NKA ☐ YES

DRUG: __________

OTHER: __________

WT: ______ kg. HT: ______ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12-15-98	0710	120cc Jennifer Moran, RN / Pel Rochelle RN
12/15/98	0930	Send Blood Cultures and Urine Analysis V.O. Dr. Summers / Pel Rochelle RN Pel Rochelle RN

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

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WILFORD ,KANE **
BM Age 24y DOB 05/14/74
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ORDERED DATE	TIME	ORDERS — Use Ball Point - Press Firmly
12/13/98	1:50pm	~~D~~NS IL bolus now. ~~D~~/C Tylenol RENEE' JARVIS, RN Hurtado 23281
12/13	1420	V.O. Dr. Hurtado # 23281 Reconsult PT for evaluation and Rx Activity level - bedrest Dr. Hurtado / Anna Nguyen, PT X22207 RENEE' JARVIS, RN
12-13-98 1900		12° CHART CHECK RJARVIS, RN / [illegible]
12/346	14:50	~~12°~~ chart check [illegible]
12-14-98 0700		12° CHART CHECK RJARVIS, RN / [illegible]
12-14-98 0700		TRANSFUSE 2 UNITS pRBCS NOW V.O. DR. HURTADO / RJARVIS, RN RJARVIS, RN

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

ORDERED DATE	TIME	ORDERS — Use Ball Point - Press Firmly
12/13/98	1037	✓ ABG + CXR Stat
		✓ Morphine long acting repeat x 1
		✓ Ativan 6mg x1
		✓ Elavil 30mg x 1 May repeat x1
		✓ please change Foley catheter Valerie 23196
		RENEE' JARVIS, RN
12/13/98	0930	✓ 12 lead EKG
		✓ LFT's today and in am 12/14/98
		3) ~~Place DHT (Bobbitt Fibs)~~
		4) ~~Start Vivactil 5 ✓ please DHT 5~~
		RENEE' JARVIS, RN Valerie 23196
12/13/98	1104	✓ Morphine 10mg x1 now Valerie 23196
		RENEE' JARVIS, RN
12/13/98		✓ Start Ibuprofen 200 mg elixir q.i.d prn - NGT
		RENEE' JARVIS, RN Valerie 23196
12/13/98	1259	✓ ↓ T.V. to 700 Increase S/MV to 15 PSP at 15
		RENEE' JARVIS, RN Valerie 23196

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ALLERGIES: ☐ NKA ☐ YES

DRUG: ______

OTHER: ______

WT: ______ kg. HT: ______ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/14/98	1545	H/H q6° Hnguyen 23120 (NGUYEN) — RENEE' JARVIS, RN
12/14/98	1910	12° CC Jennifer Moreno RJARVIS, RN
12-14-98	2135	RT 12 - chart √ / S. [illegible] RCP
12/14/98	2345	Cefepime 1gm IVPB q8° Flagyl 500mg IVPB q6° Hnguyen 23120 (NGUYEN) — noted 12-14-98 2355 JMoreno,RN
12/15/98	0624	(Daily) (AM) Daily AM CBC + ICU panel Start from this AM [signature] 23196 — noted 12-15-98 0625 JMoreno,RN
12/15/98	0615	STAT ABG now + q AM while intubated. Bolus ↑ LNS Wean SIMV → CPAP [signature] MD Summer 23285 — noted 12-15-98 0700 JMoreno

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MEDICAL RECORDS

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

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WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ORDERED DATE	ORDERED TIME	**ORDERS** Use Ball Point - Press Firmly
12/14/98	0610	I.V. difficile toxin assay, Fecal WBC ... NEXT BM RENEE JARVIS, RN Murano 23281
12/14/98	1045	V H/H post transfusion RENEE' JARVIS, RN Nguyen 23120 (NGUYEN)
12/14/98	1200	Bactrim 8mg IV ≡ may repeat q 15 min if ↓ relief to max of 32 mg q 6° prn Atarax 2-4 mg IV q 2-4° prn Morphine Sol. 2-10 mg IV q 2-4° PRN RENEE' JARVIS, RN Sumner 23255
12/14/98		PT chart ck
12-14-98	1530	THORAZINE 25mg IV Q6° PRN HICCUPS V.O. DR. SUMNER / RENEE' JARVIS, RN RENEE' JARVIS, RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

traint Orders

Critical Care

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ALLERGIES: ☐ YES ☐ NO

Describe: _____

HERMANN HOSPITAL
Physician's Orders

1014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
		Restraint Orders - Critical Care
		Patient may be restrained with:
		- Type of restraint:
		☐ Vest ☑ Wrist ☐ Waist ☐ Other:
		- Due to (*state behavior*):
		☐ Pulling at essential tubes or lines ☐ Other:
		- For up to 24 hours (not to exceed 72 hours)
		Restraint
		- May be discontinued when (indicate desired behavior):
		☑ No longer pulling at essential tubes or lines
		☑ Essential tubes or lines are discontinued ☐ Other:
		- Check patient at least Q 1 hour and release at least Q 2 hours for personal care, positioning and skin assessment.
		- Less restrictive interventions tried prior to restraint being initiated:
		☐ Verbal reminders ☐ Family to sit with patient ☐ Other:
		☐ PT and/or ☐ OT consult for suggestions for alternatives to restraints.

Signature (Physician/Attending): V.O. DR. HURTADO Beeper #: 23381

(10/95)

Restraint Orders

Critical Care

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ALLERGIES: ☐ YES ☐ NO

Describe: _____

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
		Restraint Orders - Critical Care
12/13	0700	Patient may be restrained with:
		- Type of restraint:
		☐ Vest ☑ Wrist ☐ Waist ☐ Other:
		- Due to (*state behavior*):
		☑ Pulling at essential tubes or lines ☐ Other:
		- For up to 24 hours (not to exceed 72 hours)
		Restraint
		- May be discontinued when (indicate desired behavior):
		☑ No longer pulling at essential tubes or lines
		☑ Essential tubes or lines are discontinued ☐ Other:
		- Check patient at least Q 1 hour and release at least Q 2 hours for personal care, positioning and skin assessment.
		- Less restrictive interventions tried prior to restraint being initiated:
		☐ Verbal reminders ☐ Family to sit with patient ☐ Other:
		☐ PT and/or ☐ OT consult for suggestions for alternatives to restraints.

Signature (Physician/Attending): V.D. DR. SUMNER Beeper #: 23381

434276 (10/95)

RENEE' JARVIS, RN RENEE' JARVIS, RN

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367

WILFORD , KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	TIME	ORDERS — Use Ball Point - Press Firmly
12/13/98	0300	STAT CXR - S/P intubation, line placement STAT ABG ABG & CXR q AM while intubated Hold sedation Sumner 23285
12-13-98	0655	12° CHART CHECK RJARVIS, RN /
12-13-98	0700	✓ WEAN FiO2 Δ IVF OF D5½NS @ 20KCL TO NS V.O. DR. SUMNER / RENEE' JARVIS, RN RENEE' JARVIS, RN
12-13-98	0730	✓ SUCRALFATE 1gm NGT Q6° V.O. DR. SUMNER / RENEE' JARVIS, RN RENEE' JARVIS, RN
12/13/98	0600	✓ PAN Culture debi 23696 RENEE' JARVIS, RN
12/13/98		ETT Bundle neg current vent settings SIMV 12, VT 900, resp + PS 15 Wean FiO2 to keep Sat > 92 /

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HERMANN HOSPITAL

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WILFORD , KANE **
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1014

ALLERGIES: ☐ NKA ☐ YES

DRUG: ______

OTHER: ______

WT: ______ kg. HT: ______ cm.

ORDERED DATE	ORDERED TIME	**ORDERS** Use Ball Point - Press Firmly
12/12		✓CT [illegible] ASAP c̄ PO [illegible] Contrast
		[signature]
		RENEE' JARVIS, RN 2477
12/12		✓ ① CT Chest
		✓② NPO
		[signature] 2007
		RENEE' JARVIS, RN
12/12/98 1400		V.O. Dr. Talabe / [illegible] 10g MSO4 IV XT for ETSC [illegible]
		[signature] 23176
		[signature]
12/12/98		Lateeuty RT Consult > EPPB Q4 [illegible] Keep Sat >92 / V/O Dr Talabe / [illegible]
		[signature]
12-12-98 1930		12° CHART CHECK RJARVIS, RN / [signature] RN

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431641 (6/95)

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL STICU #19

Physician's Orders

1014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

ORDERED DATE	TIME	**ORDERS** Use Ball Point - Press Firmly
12/12/98	9 am	TRANSFER to STICU Trauma, Dr Duke
		Dx S/P GSW, Respiratory Distress
		Cond: Guarded
		Vitals: Cont Monitor
		Activity: OOB TID, ~~Ed~~
		Nursing: Foley to gravity, CT to waterseal, Strict I/O, TED + SCD(B)LE,
		Diet: Clear liq.
		IV: D5 1/2 NSS 20 KCl @ 125 cc/hr
		Meds: Tylenol 650 mg po/pr q 4° prn temp/pain
		Ativan 2 mg IV q 2-4° prn agitation
		MSO4 2 mg IV q 2-4° prn agitation
		Vicodin 1-2 po q 3° prn pain
		Phenergan 12.5 mg IV q 4-6° prn N/V
		Restoril 15-30 mg po qhs prn insomnia
		Labs: CBC D/P Chem 7 500 am
		O2 to keep sats > 93%
		CT of Abd w contrast today. #141
		RENEE' JARVIS, RN

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

ORDERED DATE	TIME	**ORDERS** — **Use Ball Point - Press Firmly**
12/11/98		RT chart LeRoy Lowder
12/12/98	150 pm	Lasix 10mg IV now done Restoril 15mg-30mg po ~~prn~~ prn insomnia Warnock 23267 Pat Bryant RN 12/12/98 715
12/12/98	715 AM	Chart Check — Pat Bryant
12/12/98	615	12° cc chest Xray Pa done
12/12/98	915	Lasix 20mg IV now Warnock 23207 Pat Bryant RN 12/12/98 940 AM

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DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

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ORDERED DATE	TIME	**ORDERS** Use Ball Point - Press Firmly
12/11-98	1530	Transfer to SICU - Trauma Service Dr. Duke.
		DX - S/P GSW to abdomen/chest S/P ex. lap c ligation of common hepatic artery & cholecystectomy
		cond - stable
		vitals - per routine
		Activity - OOB to chair tid, as tolerated
		Nursing - Foley to gravity, chest tube to H2O seal strict I's + O's, TED's + SCD's (B)CE, clamp DHT
		Diet - clears
		IVF - D5 ½NS + 20mEq KCl @ 125cc/hr
		Meds - ① ~~Sweet~~ Tylenol 650mg po/pr q 4-6° PRN temp >101.5
		② Ativan 2mg IV q 2-4° PRN agitation
		③ MSO4 2mg IV q 2-4° PRN agitation
		④ Vicodin 1-2 tabs q 3° PRN pain
		⑤ Phenergan 12.5mg IV q 4-6° PRN n/v
		⑥ Benadryl 25mg IV q HS PRN insomnia.
		Labs - CBC c P/D, Chem 7 in AM.
		FM @ 6-10L flow to keep sat >93%
		Call MD if SBP <90 >180, DBP <50 >110, HR <50 >130 temp >101.5
12/11/98		Hnguyen 23120 (NGUYEN)
		12/11/98
		1/2 qd
12/11/98	7:10	TPPB q 4 hr

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ALLERGIES: ☐ NKA ☐ YES

DRUG: ____

OTHER: ____

WT: ____ kg. HT: ____ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/11	0630	Hold TF until KUB cleared
		V.O. Dr. Hurtado / R. Brutscher RN
		R. Brutscher RN
12/11	0700	12° Chart ✓ R. Brutscher RN / [illegible]
12/11/98	0940	CXR now [illegible] 23196
12/11/98	1000	C.L. diet ✓
		If tolerating [illegible], D/c diet
		[illegible] → H_2O [illegible]
		C. Littlefield [illegible], MD
		[illegible] 23285

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DRUG: ____

OTHER: ____

WT: ____ kg. HT: ____ cm.

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ORDERED DATE	TIME	ORDERS — Use Ball Point - Press Firmly
12/10/98	1522	LFT in AM
		QAM CBC c DIFF
		Adeli 23186
		[illegible signature]
12-10-98	1900	12° [illegible] / B. Brutscher RN
12/10	1930	Phenergan 12.5 - 25mg PRN
		V.O. Dr. Hortado / B. Brutscher RN
		R. Brutscher RN
12/10/98		[illegible]
12/11	0300	Reglan 10mg IV now
		V.O. Dr. Hortado / R. Brutscher RN
		B. Brutscher RN
		Chem 7 in am
12/11	0300	KUB in 3 hrs. done
		V.O. Dr. Hortado / R. Brutscher RN
		R. Brutscher RN

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ALLERGIES: ☐ NKA ☐ YES

DRUG: ____________________

OTHER: ____________________

WT: __________ kg. HT: __________ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/10/98	0945	1) Δ IV to D_5 1/2 NS c̄ 20 KCl @ 125 cc/hour
		2) Start TF @ 10 cc/hour Promote FS, p̄ ✓ Dobhoff ~~to~~ tube placement by MD.
		3) OOB to chair tid
		4) RT consult
		[signature] [signature] 23081
		[signature]
12/10/98	1230	VO - Dr Dunmer / [signature]
		Ibuprofen 400mg P.O. Q4° Till Fever Δ weeks
		alternate c̄ Tylenol
		[signature]
12-10-98	1430	Hold TF
		~~Advance DHT~~
		Only ice chips.
		Hnguyen 23120
		[signature]
12-10-98	1520	Start TF @ 10cc/hr
		Check residuals q 6° if >100 Hold TF
		Hnguyen 23120
		[signature]

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

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ALLERGIES: ☐ YES ☐ NO

DESCRIBE:

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	TIME
12/10/98	1000

ORDERS

Use Ball Point-Press Firmly

ORTHO/TRAUMA/PLASTICS/BURNS

Physicians Orders for Rehab Services **Diagnosis:** GSW

The appropriate indication for therapy must be checked for each modality ordered. An incomplete order or an order for therapy which is not indicated will not be initiated. You will be informed when this occurs.

Restrictions/Equipment
Weight bearing status: (Fill in appropriate items)
✓ FWB ___ NWB
___ PWB ___ WBAT
___ Extremity
___ Recent muscle flap/STSG (Extremity dependency limited to ___ minutes
___ ROM restrictions

Equipment patient has:
___ Knee immobilizer
___ TLSO
___ Corset
___ AFO
___ Splint
___ Bledsoe brace

INDICATION: Decreased function of LE, LE amputation
Order: ✓ Assess and treat

INDICATION: Risk of Deformity
Order: ✓ Assess and treat
___ Assess and splint as indicated
___ See chart for specific splinting orders

INDICATION: Decreased self care skills i.e., eating bathing, bathroom safety.
Order: ✓ Activities of daily living (ADL) assess and treat
___ Supply and instruct on use of adaptive equipment
___ Safety assessment and treat

INDICATION: Inability to ambulate safely, decreased functional mobility, non-ambulatory (draw sheet transfers are done by nursing)
Order: ___ Assess and treat

INDICATION: Status post THR, TKR, Rotator Cuff Repair, Laminectomy, ACL
Order: ___ Assess and treat per protocol

INDICATION: Musculoskeletal and/or Neurogenic pain
Order: ___ Assess and treat

INDICATION: Impaired swallowing and/or communication
Order: ___ Assess and treat
___ Speech assess during modified barium swallowing study

INDICATION: Burns
Order: ___ Assess and treat per protocol

INDICATION: P.T. Wound Care
Order: ___ Evaluate and treat
___ Specific orders: _____
_____
___ Dressings: _____
___ Evaluate and arrange for Hermann Outpatient Wound services.
___ Modalities
___ Debridement
___ Hydrotherapy
___ Pulsavac Lavage

INDICATION: Decreased hand/arm function, UE amputation
Order: ✓ Assess and treat
___ Assess and splint as indicated
___ See chart for specific splinting orders

KEY:
FWB - Full Weight Bearing
PWB - Partial Weight Bearing
NWB - Non-Weight Bearing
WBAT - Weight Bearing as Tolerated
STSG - Split Thickness Skin Graft
ROM - Range of Motion
TLSO - Thoracic Lumbar Spinal Orthosis
AFO - Ankle/foot Orthosis
THR - Total Hip Replacement
TKR - Total Knee Replacement
ACL - Anterior Cruciate Ligament
UE - Upper Extremity
LE - Lower Extremity

Physician Signature: _____
Physician Name: (please print) _____ **Beeper #:** _____
Date: _____

☐ Please have therapist contact Physician for further Rx instructions.

435406

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ____________

OTHER: ____________

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

WT: ________ kg. HT: ________ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/9/98	0430	1) Wean PS in Vent as tolerated
		2) ~~[illegible]~~ TF 15cc/hour advance as per protocol Impact
		3) Chem 7, CBC c diff, ABG while intubated q am
		4) BC x 2, ~~[illegible]~~, sputum C+S, UA
		[illegible] Hurtado 23281
		[illegible]
12/9/98 1900		12° Chart ✓ [illegible] B. Butcher RN
12/9/98		~~12° [illegible]~~
12/10/98	0200	① Turn pt Ⓡ side down
		② Reglan 10mg IV x 1 now
		③ KUB c Add CXR [illegible], MD Summer 23283
		R Butcher RN
0200	12/10	12° Chart ✓ B. Butcher RN [illegible]

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431641 (6/95)

MEDICAL RECORDS

traint Orders

DEC 0 8 1998

Critical Care

Authorization is hereby given to dispense the Generic or Chemical Equivalent unless otherwise indicated by the words "MEDICAL NECESSITY."

ALLERGIES: ☐ YES ☐ NO

Describe: _____

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
		Restraint Orders - Critical Care
		Patient may be restrained with:
		- Type of restraint:
		☐ Vest ☐ Wrist ☐ Waist ☐ Other:
		- Due to (*state behavior*):
		☐ Pulling at essential tubes or lines ☐ Other:
		- For up to _____ hours (not to exceed 72 hours)
		Restraint
		- May be discontinued when (indicate desired behavior):
		☐ No longer pulling at essential tubes or lines
		☐ Essential tubes or lines are discontinued ☐ Other:
		- Check patient at least Q 1 hour and release at least Q 2 hours for personal care, positioning and skin assessment.
		- Less restrictive interventions tried prior to restraint being initiated:
		☐ Verbal reminders ☐ Family to sit with patient ☐ Other:
		☐ PT and/or ☐ OT consult for suggestions for alternatives to restraints.
		Signature (Physician/Attending): _____ Beeper #: _____

434276 (10/95)

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words-**MEDICAL NECESSITY**"

ALLERGIES: ☐ YES ☐ NO

DESCRIBE:

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	ORDERED TIME
12/08/98	0640

ORDERS — Use Ball Point-Press Firmly

Electrolyte Replacement

Disregard all protocols if patient has renal failure, is on dialysis, or has a creatinine clearance <30 ml/min.
Please fill in the electrolyte level and check the appropriate box.
Patients LBW= _____kg

Magnesium Serum magnesium level: _____mEq/L 1.1 mg/dl
Magnesium level 1.0-1.7 mEq/L
☒ Magnesium Sulfate 0.5 mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 3 days.
Recheck magnesium level in 3 days.
Magnesium level < 1.0 mEq/L
☐ Magnesium Sulfate 1mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 1 day, then 0.5 mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 2 days.
Recheck magnesium level in 3 days.
If patient has gastric access and needs a bowel regimen,
☐ Milk of Magnesia (MOM) 15 ml q 24 per gastric tube (NG,OG, PEG). Hold for diarrhea.

Phosphate Serum phosphate level: 2.3 mg/dl
Phosphate level 1.0-2.5 mg/dl:
☐ Tolerating enteral nutrition: Neutra-Phos 2 packets q 6 h per gastric tube or feeding tube.
☐ No enteral nutrition: $KPHO_4$ or $NaPHO_4$ 0.15 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level in 3 days.
Phosphate level < 1.0 mg/dl:
☐ Tolerating enteral nutrition: $KPHO_4$ or $NaPHO_4$ 0.25 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level 4 hours after end of infusion. If <2.5 mg/dl, begin Neutra-Phos 2 packets q6h.
☐ Not tolerating enteral nutrition: KPHO4 OR NaPHO4 0.25 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level 4 hours after end of infusion. If < 2.5 mg/dl, then KPHO4 or NaPHO4 0.15 mMol/kg (LBW) IV over 6 hrs x 1 dose.

Calcium Serum normalized ionized calcium level: 4.2 mg/dl
Normalized calcium level <4.0 mg/dl:
☐ With gastric access (NG, OG, PEG) and tolerating enteral nutrition:
Calcium carbonate susp 1,250 mg/5 ml q6h per NG, OG, or PEG
Recheck ionized calcium level in 3 days.
☐ Without gastric assess or not tolerating enteral nutrition:
Calcium gluconate 2 gm IV over 1 hr x 1 dose.
Recheck ionized calcium level in 3 days.

Potassium Serum potassium level: _____mEq/L
Serum potassium level <4.0 mEq/L:
☐ Asymptomatic, tolerating enteral nutrition: KC1 40 mEq per enteral access x 1 dose.
☐ Asymptomatic, not tolerating enteral nutrition: KC1 20mEq IV q 2h x 2 doses.
☐ Symptomatic: KC1 20 mEq IV q1h x 4 doses.
Recheck potassium level 2 hours after end of infusion. If <3.5mEq/L and asymptomatic, replace as per above protocol.

Date	Time	Physician Signature	Physician Name(Print)	Beeper Number
12/08/98	0630			233x1

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

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